Jurisdiction

And

First Nations Health and Health Care

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ABSTRACT

Research indicates that the health of Aboriginal people is improving; however, there continues to be a significant gap between the health status of First Nation peoples and the health status of all other Canadians. Several determinants of health contribute to differences in health status, and the use of health services and access to these services are determinants that are important for the health status of First Nation peoples.

There are many reasons for variations in the delivery of health care. Ambiguity in defining government level responsibility for health service delivery is hypothesised to have a negative impact. Compounding these effects is the direct conflict between stakeholders at each level involving jurisdictional responsibilities, the sharing of resources, and the perpetuation of existing structures.

This study documents the health care delivery systems providing services for First Nation peoples, and reviews factors influencing access to health services within a historical and contemporary policy context. A review of relevant policy documents and archival materials is carried out to document how jurisdictional issues at the federal and provincial government levels have affected First Nation peoples ability to access or to deliver service. Key informant interviews with policy-makers and health care professionals were used to document their perspectives on jurisdiction. These ethnographic case studies examined real or perceived barriers in access to service or gaps in service for First Nation peoples, and the relationship to jurisdictional issues.

This study has identified outstanding issues in jurisdiction, and some potential reasons why resolution of this jurisdictional ambiguity has not occurred. Key informant perspectives and policy document review have acknowledged the critical effects of

jurisdictional ambiguity and its resultant outcomes on the health status of First Nation peoples. Resolution of jurisdictional issues in health care and social programming is a key factor for the enhancement of health status of First Nation peoples.

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EXECUTIVE SUMMARY

This study documents the philosophies, the beliefs, and the experiences of federal, provincial, and First Nation decision makers, administrators and health care providers in dealing with jurisdictional issues in the field of health services delivery for First Nation peoples in Manitoba. It describes the present system as viewed by these individuals, and their understanding of the issues arising in health care delivery. It describes the approaches they take in managing programs or service delivery for First Nation peoples within a system that has, for the last one hundred and fifty years, focused on divesting itself of that responsibility.

This qualitative study was designed as a critical ethnography, using semi-structured interviews with key informants to develop case studies. The Health Information and Research Committee (HIRC) of the Assembly of Manitoba Chiefs (AMC) provided support and direction for this study, and the research protocol was reviewed by representatives of HIRC to allow feedback following completion of the report. Some participants reviewed excerpts from their narrative and commented on the interpretation of themes and conclusions.

KEY THEMES

Key themes were identified in the critical review of documentary data and analysis of key informant interviews. Secondary, or 'minor' themes, were consistent with, and reinforced the primary thematic codes of jurisdictional ambiguity and jurisdictional responsibility. Dominant themes included:

1. historical effects of colonialism;
2. Aboriginal (First Nations) rights;

3. access to service; and

4. fiscal responsibility.

The Historical Effects of Colonialism

The lasting effects of colonization, coupled with the demographics and the social and economic status of First Nation peoples in Canada, have had a profound affect on the health, and health care of the people (Postl et al, 1995; Comeau and Santin, 1990). In the face of evolving legislation, policies and on site development of service delivery systems that have resulted in assimilation and subjugation; the struggle for self-determination by First Nation individuals and communities is an example of their resiliency and strength. Key informants described a culture of systematic avoidance by government for the provision of adequate health services for First Nations. Ambiguity at the level of policy making, decision making for funding allocations, and in the service delivery system was identified by key informants as a reflection of the historical impact of colonialism.

Aboriginal (First Nation) Rights

First Nation leadership and the grassroots movements have sustained their belief in the inherent rights of the First Nations of this country. The unrecognized rights of the First Nation peoples is a historical challenge and continues today. A lack of trust in government commitments and the resultant fragmentation of services for First Nation peoples is reflected in the health status of the people. Study participants described many situations illustrating the impact of governments' refusal to entrench the rights of First Nation and Aboriginal peoples, and elaborated on how this has aided in fostering Canadians' beliefs that both the Aboriginal peoples and the Aboriginal governments do not have rights.

Access to Service

The perceptions of the limited rights of First Nation peoples have resulted in negative attitudes in Canadians. These negative attitudes have been reflected in discriminatory behaviors directed at First Nation peoples. Key informants described situations illustrating how these behaviors have affected First Nation peoples' access to service. Informants also emphasized that there is reluctance of governments to acknowledge the need to collaborate and identify gaps in service provision. These factors perpetuate unequal access to services. Informants suggested that barriers to service result when vague and covert policies are allowed to continue.

CONCLUSIONS

Jurisdictional Ambiguity

Key informants shared their perceptions of the effects of sustained historical jurisdictional ambiguity on the health status of, and access to health care for, First Nation peoples. This ambiguity has resulted in unclear policies and in the provision of insufficient health service resources. It has been reflected in the lack of cohesion and integration in health and social program planning and in service delivery. The lack of clarity has had significant negative affects on First Nation peoples health status and general well-being.

Informants suggested that government has benefited from the secondary gain of sustaining the jurisdictional ambiguity. Responsibility for providing comprehensive health and social services programming, and the resultant fiscal accountability for these programs for First Nation peoples, has not been assumed. Fragmented services have been off-loaded to the provinces through the decreasing funding allocations of the federal

transfer payments, or to the First Nations through the health transfer process, without sufficient resources to sustain them. Strategies to integrate services for collaboration in addressing health issues have not been initiated.

The historical efforts of the federal government to assimilate First Nation peoples, and the resistance to formally accepting the responsibility for provision of health services specific to First Nations, has resulted in fragmentation of critical health and social programs. The ongoing reluctance of the federal government to assume a full or equitable responsibility for funding of health and social programs for all Canadians at the provincial levels has compounded the fragmentation of service delivery.

One outcome for First Nations, in successfully resisting assimilation, includes marginalization of First Nation peoples. This marginalization is evident in the approach to First Nations politics and governance, in strategies for health and social service delivery, and in access to initiatives that would recognize the abilities and accomplishments of First Nation individuals and communities in this country.

Jurisdictional Responsibility

Concerns were expressed that the historical reasons for First Nation marginalization, in health and other areas, rests with the legislative structure for governance of First Nations in Canada. The initial establishment of a relationship between First Nations and Parliament was not sustained by a commitment to clearly define the relationship for future governance. Participants indicated that since the responsibilities of the federal government have not been clearly defined by the federal government in relation to provincial governments or to all Canadians, First Nation peoples have experienced the results of this ambiguity in every component of their lives.

The attitudes of the Canadian politicians and population toward First Nations, which are reflected by the political decisions, have had negative outcomes for First Nation peoples when establishing resources for sustainable programs. They have also affected the ability of First Nations to establish governance, justice, and education programs that meet the needs of the First Nation peoples.

Fiscal Responsibility

There is a perception that financial reasons drive the decisions by government to continue maintenance of the ambiguity and contesting of First Nations entitlement to benefits. Participants felt that a pervasive and systematic philosophy of resistance to resolving these issues has driven the process. Efforts to minimize financial responsibility are reflected in the lack of adequate resources for sustainable and effective programs that would address the disparate health status of First Nation peoples.

SUMMARY

Informants described the key challenges to be met in resolving jurisdictional ambiguity and responsibility. The key challenges were identified as:

1. the need for recognition of First Nations as equal partners in governance;
2. the need to actively involve First Nations in the development of community relevant programs and services; and
3. the need to insure an increase of power by First Nations over policy decisions and management of service delivery in community.

Adequate resources must be made available, and the ability to make decisions on how to re-profile resources to meet the needs of communities must be possible.

CHAPTER 1

INTRODUCTION

A discussion of the health status and health care delivery systems for First Nation peoples is not complete without exploring the effects of jurisdiction and jurisdictional responsibility. In the literature, most discussions of the effects of determinants of health on health status do not include reference to the effects of jurisdictional issues. For effective and efficient health care delivery, there is a need for inter-sectoral and intra-sectoral collaboration in health care program planning (Royal Commission on Aboriginal People, 1996; Health and Welfare Canada, 2002; Manitoba Health, 1999; Winnipeg Regional Health Authority, 2002). Health care planning for First Nation peoples should involve inter-sectoral communication and collaboration between federal government departments, as well as with provincial and First Nation governments. Without established process, there will continue to be a lack of clarity in defining roles and responsibilities of the government departments. Some areas necessary for health service delivery that are affected by jurisdiction include:

- Infrastructure development (Information systems, physical space, etc.)
- Human resources recruitment and development
- Financial resources
- Health program development, implementation and management
- Patient care co-ordination and case management
- Environmental protection and public health legislation
- Resource levels and management capability in each of these areas affects the level and quality of health care service.

This study established as its objectives the task of documenting the current health care system for First Nation peoples; and identifying barriers to health services, gaps in service or risks to the health of First Nation peoples as a result of unresolved jurisdictional issues. It reviews how jurisdiction has affected the ability of First Nation peoples to access health care.

First Nation communities are communities with a federal land base situated geographically within provincial Regional Health Authorities. Ambiguous interpretation of legislation and policy at the federal and provincial levels has resulted in poorly defined jurisdictional and fiscal responsibility for health services for First Nation peoples. Funding for health and social services delivery for First Nation communities is fragmented, in part, as a result of the geographic and jurisdictional boundaries (Figure 1).

A review of relevant policy documents and archived materials has been used to describe the historical evolution of the relationship between jurisdictional responsibility and service provision for First Nation peoples. Supporting legislation was reviewed in the context of health services for First Nations. Ethnographic case studies as described by informants further examined this relationship. Key informant interviews with policy makers, health care administrators and health care professionals were used to examine the perspective of persons involved in administrative and policy roles on jurisdictional issues. Participating key informants included individuals from within the federal, provincial and First Nation government and health service systems.

The health of Aboriginal[1] people has improved over the last several years; however, there continues to be a significant gap between the health status of First Nation peoples, and the health status of all other Canadians (Health Canada, 1999; Manitoba Health, 2002; Statistics Canada, Census Data 2001; Martens et al, 2002; Health Canada: First Nations and Inuit Health Branch, 2002). There are multiple and mutually interacting determinants of health status. Health service delivery systems, and the ability of communities and individuals to access these services, are important determinants of health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999; Tjepkema, Supplement to Health Reports, Statistics Canada, 2002; Lurie et al, 2002; Frank, 2003; Health Canada, Towards a Common Understanding, 1996). There are many causes underlying variations in the delivery of health care; and jurisdictional ambiguity and conflict can influence the level and quality of health services delivered (Craig, 1992; Hanselmann, 2003).

Background: Policy and Health Services Development

The British North America Act (BNA) of 1867 established a relationship between the First Nation peoples of Canada and the federal government. Parliament was deemed to have responsibility for the Indian people in Canada. The BNA Act also gave responsibility for health care to the provincial governments. That proclamation has resulted in a historical situation of jurisdictional ambiguity. The degree of governmental responsibility between the federal and provincial governments for health services for

[1] Statistics Canada's 2001 Census defined Aboriginal persons as people who reported identifying with at least one of: North American Indian, Metis or Inuit and or persons defined as Registered or Treaty Indians under the Indian Act, and or who were members of an Indian band or First Nation.

First Nation peoples has never been clarified in a manner that would facilitate a seamless continuum of care for First Nation peoples.

A specific area of ambiguity has been in the area of responsibility for the level of health service provided on-reserve by federal and provincial governments. Historically, neither government – federal or provincial – have established or acknowledged a level of responsibility for the health care of First Nations. The 1964 Agreement between Canada and Manitoba (Appendix 1) is a memorandum of understanding outlining how governments will deliver health services in northern communities in Manitoba. This agreement is an example of how governments, when convenient, will swap responsibility for service delivery for First Nation peoples. The 1964 Agreement was established without the involvement of First Nation or Aboriginal peoples.

The ambiguity surrounding the jurisdictional responsibilities of government for First Nation peoples health care has resulted in situations wherein service was denied to First Nation peoples, particularly if they resided on reserve. In 1979, the Winnipeg Tribune reported:

> "Intolerable Situation: A Manitoba judge has turned the judicial spotlight on an intolerable situation in this province for all to see, and for the federal and provincial governments to rectify immediately.
>
> It concerns treaty Indians on the (...) Reserve and the social services which they have not been receiving; services which other Manitobans receive as a matter of course....Judge Garson...was told that the provincial government doesn't 'supply, provide or give their range of services to treaty Indians' on reserve.
>
> But Judge Garson noted that the same services were provided to others in the area, provided the residents are 'white or non-treaty Indians.'....Judge Garson put his finger on the nub of the problem: the federal government has a special responsibility towards treaty Indians under the British North America Act, but it maintains that health and welfare is a provincial responsibility. For its part, the provincial government maintains it is

> excused because of the special historical and constitutional relationship between the federal government and the treaty Indians.
>
> A classic example, in other words, of buckpassing." (The Winnipeg Tribune, August 2, 1979, Tribune Editorial).

Although this report focused on a situation on a Manitoba First Nation reserve, similar situations have occurred nationally.

Several studies, Round Tables and Forums have focused on the health of First Nation peoples over the last several decades, the most significant of which was the Royal Commission on Aboriginal Peoples (RCAP). These reviews have all identified, as a priority, the need to address jurisdictional issues in entitlement and delivery of health care. This action is considered to be imperative in order to provide co-ordinated health services which are holistic, and which address the health needs of Aboriginal people (Royal Commission on Aboriginal People (RCAP), 1996; Canadian Medical Association: Bridging the Gap, 1993; Manitoba Health, Quality Health Care for Manitobans, 1999).

Review of the Canadian system of universal health care has resulted in health reform at a provincial and national level. These efforts have focused on the need to change the way health care services are delivered. Sustainability of the present health care system is jeopardized by the escalating costs of health care. The federal government has changed the way it provides financial support for universal and comprehensive health care as defined by the Canada Health Act. Most health reforms have placed emphasis on the need for alternative care levels that are community based. Having people returned to their families and their communities as soon as possible, with supports in place for convalescence, is preferable to keeping people in hospital. It is also more cost effective. First Nation communities have not had the same degree of infrastructure and resource building, such as home care and other allied health supports, at the community level as

have non-First Nation communities. They are less able to accommodate the expectations of health reform for an enhanced level of community based care.

In addition to difficulties in accessing health care services, the literature clearly supports the concept that disparities in social and economic status have an effect on the health status of a population (RCAP, 1996; Frank et al, 2003). Poverty, economic stability, lifestyle stability, and food security are some of the variables that affect health status. It is also acknowledged that culture and being members of a specific population group have significant effects on health status (AFN, 1999; Statistics Canada, Winter Report, 1999; Hanselmann, 2003). Evidence of the impacts of all of these factors exists in the health status of First Nation peoples. There is a need to effect a change in ongoing social disparities and to ensure equitable access to all health care services in order to improve the health status of First Nation peoples.

Jurisdictional ambiguity has allowed both levels of government to minimize responsibility for First Nation peoples entitlement to health service. The Indian Act does not define the responsibility for the provision of health services for First Nations, and provincial governments have not explicitly asserted jurisdiction in relation to health. Since jurisdiction carries with it financial responsibility, provinces have not contested the federal governments responsibility to provide health care to First Nations (Craig, 1992). As a result, neither level of government acknowledges a mandate to provide co-ordinated health care to First Nation peoples on and off-reserve. The federal government maintains that they provide health services for First Nations as a matter of policy and practice, and not as a result of a constitutional or treaty obligation (Young, 1984; Romanow Commission, 2002). Federal/provincial relations over the previous half century have

generated very little activity which promotes collaboration between governments in planning and delivering health service in First Nation communities (Lazar et al, 2002; Weaver, 1985).

Impact of Federal Assimilation Policies

Although not specific to health care, the policies of assimilation in the 1830's and 1840's set the tone for the process of future interactions with First Nation peoples in this country. Thomas Berger (1991), in 'The Long and Terrible Shadow' highlights the impact of colonisation on culture, on health, and on self-identity:

> "These are not simply questions of disease, its prevention and cure. They are a cluster of social pathologies that threaten the lives of Native persons and undermine the social life of Native communities...European contempt and indifference towards Indians and Indian culture have persisted into our own time, though today their outward manifestation takes a different form than it did five hundred years ago. In the same way, the destruction that the Europeans brought is still with us today, though in a different form." (p. 27)

First Nation peoples have not had a respectful acknowledgement of their status as the indigenous peoples, nor of their contribution to this country. The dominant society in Canada has been effective over time in establishing the concept of Aboriginal peoples as a group to be feared, shunned, or ignored.

This imagery of Aboriginal peoples as a marginalized population is present in all of the social networks in Canada. The effects of this imagery, and subsequent behaviours and attitudes by non-Aboriginal peoples, are reflected in the established policies and processes within the health system, the justice system, the education system and social support systems. The need for collaboration between sectors has been recognised. Pervasive negative attitudes within systems create added difficulties when attempting to integrate services between systems.

The justice system is overwhelmed with an inability to meet the needs of the Aboriginal population. It is a system where Aboriginal people are disproportionately represented among the residents of prisons and detention centres. The education system presents an established curriculum that has an ambiguous reality for Aboriginal children, and portrays Aboriginal people as a violent people, with little to contribute to society. Burnford (1969) summarizes the teaching of the prevalent theories of First Nation peoples:

> "The history books he showed me contained little of Indians except their ultimate defeat and submission – (one could not help getting the impression that those who resisted the invasion of their territory had done so in a very ungentlemanly way; first they "rose" and then they "massacred"; whereas the invaders, having failed to "quell" these uncouth risers, thereafter merely "subdued" them). There were many lengthy accounts of the first great explorers...all of whom would have perished without the endurance and skill of those anonymous people who not only guided them but taught them how to survive, without the courtesy, help and hospitality of the many unmentioned tribes along the way." (p. 233)

Terminology in the literature has changed over the last several decades, but inherent perceptions are difficult to modify without education and exposure of the general public to the positive culture of the First Nation peoples.

The health care system has not been sensitive to the culture of the First Nation peoples, and has not been effective in engaging First Nations in health care planning in a meaningful way. As Tookenay (1996) remarked "It is difficult to establish true partnerships between different societies when one is subject to the discretionary power of the other". (p. 1582)

Future Challenges

The inequities in the health status of Aboriginal and First Nation peoples in Canada have largely been ignored over the last century. Sporadic efforts to address these

health issues have not been in the form of long-term commitments by government, at either the provincial or federal level. Initiatives proceed without the active involvement of the Aboriginal and First Nation communities.

The federal and provincial governments are now challenged with maintaining a viable health care system with escalating expenditures. Costs for First Nation health services have increased significantly over the last few decades (Health Canada, NIHB Annual Report, 2001/2002). The population has increased, and utilization rates of health benefits have increased. First Nation peoples experience a burden of chronic illness and subsequent morbidity that far exceeds that of other Canadians. As a result, the non-insured health benefits costs for prescription drug use, and medical transportation have also far exceeded the anticipated budgetary expenditures of Health Canada's First Nations and Inuit Health Branch (FNIHB).

Most recently, the "Romanow Commission" was established by the federal government with a mandate to assess the future of health care in Canada. The final report document of the Commission on the Future of Health Care in Canada was entitled "Building on Values", and included a chapter on Aboriginal Health. This chapter, entitled "A New Approach to Aboriginal Health", reviewed the present system of services for Aboriginal peoples in Canada. They indicated that there is "a disconnect between Aboriginal peoples and the rest of Canadian society, particularly when it comes to sharing many of the benefits of Canada's health care system." (Romanow Commission, 2002, p. 12). The underlying reasons cited for this disconnect include: 'competing constitutional assumptions, fragmented funding for health services, inadequate access to health care services, poorer health outcomes, and different cultural

and political influences.' (Romanow Commission, 2002, p.12). The Commission reviewed the financial costs of health services for First Nation peoples, and heard the political opinions on the jurisdictional responsibility for health services for First Nation peoples. Consistently emphasized by participants in the hearings was the need for more active participation of Aboriginal peoples and communities in deciding the health services profile. There was a conviction by some, through reports to the Commission, that improvement in health status and resolution of problems in health services will only occur with more autonomy for First Nations in program development and service provision. The report discussed the need for integrating services and indicated that "given the overlapping responsibilities and the complexity of the health issues involved, better results could be achieved by sharing responsibilities rather than jealously guarding jurisdiction." (p. 221) The recommendations for Aboriginal Health, are summarized as 'Directions for Change' (p. 211):

- Consolidate Aboriginal health funding from all sources and use the funds to support the creation of Aboriginal Health Partnerships to manage and organize health services for Aboriginal peoples and promote Aboriginal health,
- Establish a clear structure and mandate for Aboriginal Health partnerships to use the funding to address the specific health needs of their populations, improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers, and
- Ensure ongoing input from Aboriginal peoples into the direction and design of health care services in their communities.

A critical first step to begin to address these ongoing health related issues is by establishing a process for a collaborative approach to integrated service delivery.

1.1 Objectives

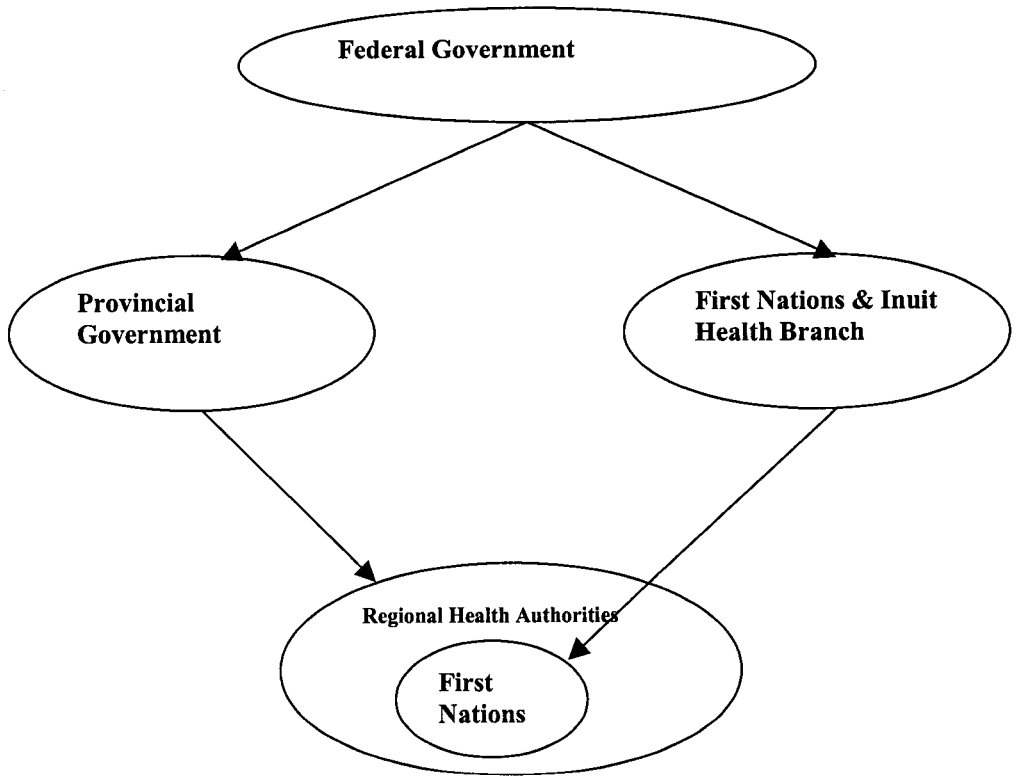
The overall objectives of this study are to review the health care delivery system for First Nation peoples. This study will explore how unresolved jurisdictional issues at the federal and provincial levels may have had an affect on the ability of First Nation peoples to access health services, or to deliver health services. This will be achieved by:

1. Documenting the current health care system for First Nation peoples in Manitoba, including the affects of established Health Transfer, through a review of policy documents and literature.
2. An ethnographic study through key informant interviews and case studies to illustrate perceived or real barriers in access to health service, gaps in service, or risks to health for First Nation peoples as a result of unresolved jurisdictional issues.

1.2 Theoretical Framework: Health Services for First Nation Peoples

The health of a population is affected by all of: health services, rehabilitative and support services, eligibility for benefits, education and social factors, economic and employment factors, and the degree of control that one has over their decisions (F/P/T Advisory Committee, 1994; Frank, 2003). The conflicting messages from government and subsequently from service providers, as a result of jurisdictional issues, minimizes the control that First Nation individuals have over health and health care decisions.

Figure 1: Framework for current health service delivery in Manitoba



The current structure of the health services delivery system for First Nations in Manitoba is complex. As indicated, the First Nation communities are situated on a federal land base geographically within provincial health authorities. The First Nation

communities receive funding from the federal government for community-based programs in health promotion and prevention and some primary care service. Some community-based programs include health promotion programs in diabetes and prenatal nutrition; and prevention programs in fetal alcohol syndrome, injury prevention, and drug and alcohol prevention. The Brighter Futures and Building Health Communities programs are aimed at addressing some of the social service needs of communities in the areas of mental health supports, healthy babies, child development, parenting skills, and also include injury prevention. More recently, the federal government has begun to establish home care programs on reserve.

Provincial regional health authorities receive funding from the provincial government for the delivery of insured health services. These insured services include physician and hospital based services, in addition to some programs such as home care and other allied health services. In Manitoba, some insured services are delivered on reserve, but programs like home care, and diabetes education are not. Global funding from the federal government to the provinces provides the basis for the delivery of insured health services for First Nation peoples and communities.

This study will explore the perceptions and real affects, of jurisdiction on health and health service delivery. It will review the policy directives that have resulted in the present health care delivery system. It will explore perceptions of, or real gaps or barriers to service, and will identify risks to health of First Nation peoples as a result of jurisdiction. Finally, initiatives that have addressed jurisdiction and potential strategies for resolution of jurisdictional issues in health care will be identified and explored.

CHAPTER 2

LITERATURE REVIEW

A review of the literature drew on historical and contemporary information to illustrate First Nation issues in health and social services, and the jurisdictional issues which define the parameters of service delivery in those areas.

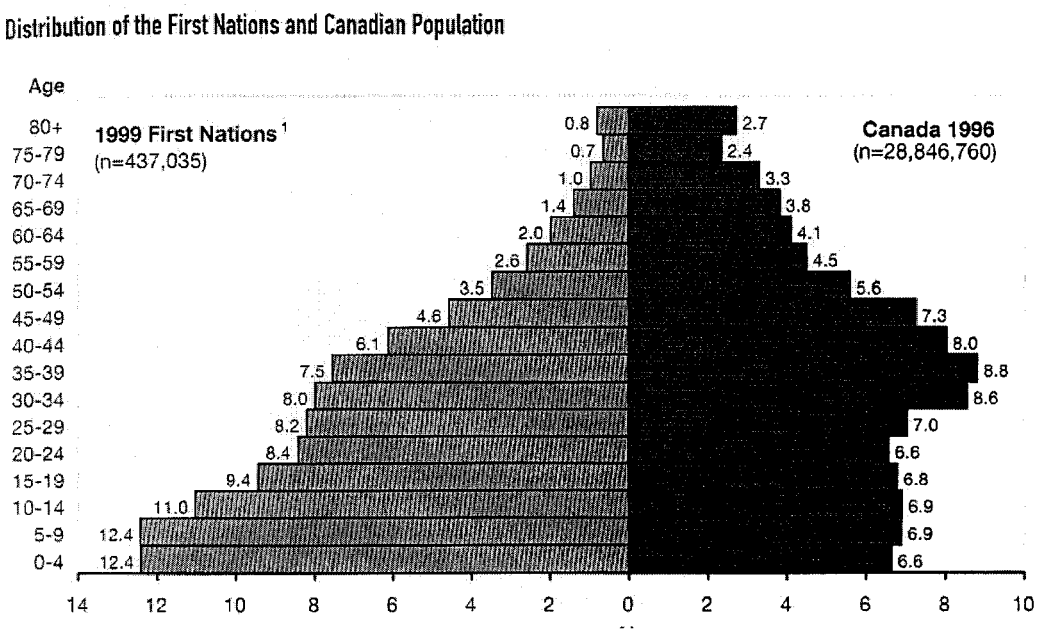
The persistent effects of colonialism on the health and well-being of First Nations are explored through a description of the historical evolution of policy for assimilation and for health service delivery. The need to establish Aboriginal rights as a basis for future development, and some of the reasons for inactivity in this area are discussed. The ongoing pressures of financial responsibility for health and social services are reviewed, and the potential reasons for reluctance in commitment to a mandate for First Nation health services are suggested from a national, provincial and First Nations perspective.

The Aboriginal and First Nations populations are increasing at more than twice the rate of other Canadians. Concurrently, the rates of chronic disease are increasing, and First Nation peoples are living longer. As the population increases and ages, the potential for significant financial costs for the delivery of First Nations health services becomes evident. Present concerns regarding the sustainability of universal health care compound the reluctance for commitment to a system of comprehensive and integrated services for First Nations.

2.1 Population Context of First Nation Peoples in Canada and Manitoba

The 1996 Canadian Census reported that 11.7% of Manitoba's total population consisted of Aboriginal people. First Nation peoples account for 63.5% of the total Aboriginal population in Manitoba. Geographically, 35.5% of Manitoba's Aboriginal people lived in Winnipeg. At that time, 27% of the First Nation peoples lived in Winnipeg, with 58% of First Nation peoples living on reserve. Forty-two percent of Aboriginal people lived in the northern part of Manitoba, with 83% of this sub-population consisting of First Nation peoples. Manitoba has a higher percentage of First Nation peoples living on reserve in isolated communities than any other province (Statistics Canada, 1996).

Figure 2: Population Distribution of the First Nations and Canadian Population



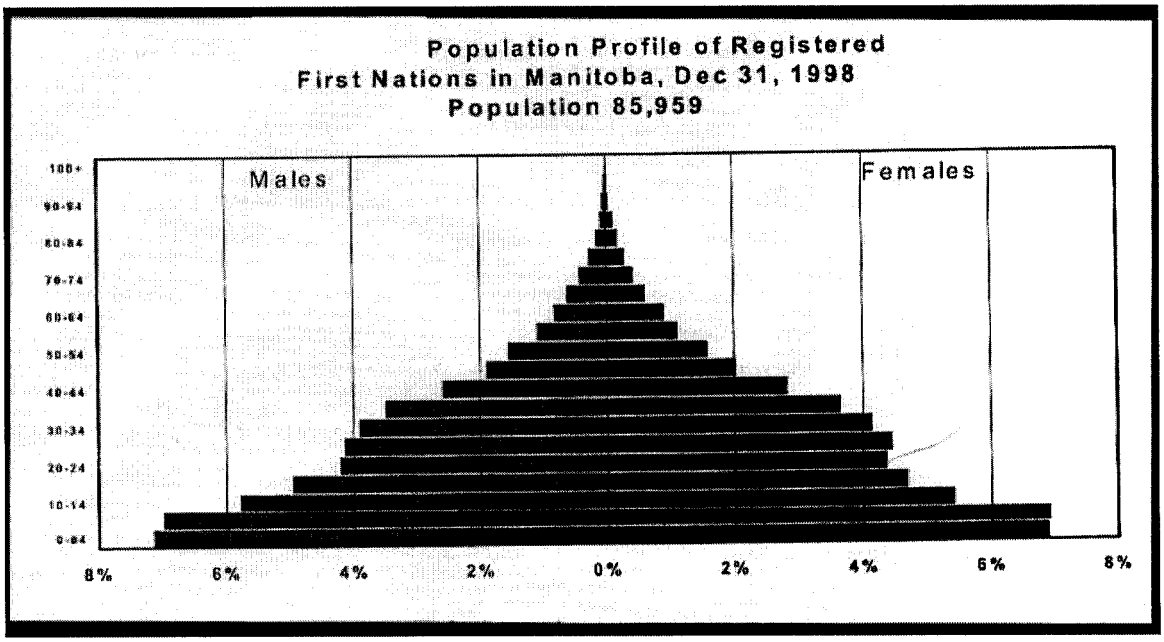
Source: Health Canada, A Statistical Profile of the Health of First Nations in Canada.

New data from the 2001 Census indicates that Aboriginal people comprise just a little more than 1.3 million, or 4.4% of Canada's total population (Statistics Canada,

2001). Of this group, 62% reported that they identified as North American Indian, or registered First Nation peoples. The census identified 15% of the total Aboriginal Canadians as resident in Manitoba, with 8% of all First Nations people resident in Manitoba (Statistics Canada; Aboriginal peoples of Canada: A demographic profile, 2001). Less than one half (47%) of the First Nations population lived on reserve, with the majority living either in urban centres, or in rural off-reserve locations. Greater than 55,000 Aboriginal people live in Winnipeg, Manitoba, representing 8% of that city's total population. Winnipeg had the largest First Nations population in a Canadian urban area at 22,955 (almost one half of the Aboriginal population of Winnipeg).

The population profile of First Nation peoples indicates a young population that has had significant growth with a small, but increasing number of seniors.

Figure 3: Population Profile of Registered First Nations in Manitoba, 1998 Population 85,959



Source: Manitoba Centre for Health Policy, Health and Health Care: Manitoba First Nations

The lower health status of First Nations populations and an increasing burden of chronic disease within this population reinforces the need to focus on the determinants of health and the health care needs of this population (Martens et al, 2001).

2.2 First Nations Health Status

The health status of individuals is influenced by many variables producing direct impacts in synergy. However, most determinants of health lie outside the realm of health service delivery. The literature is consistent in its conclusions on the effects of multiple determinants. The Regional Health Surveys conducted by First Nations nationally concurred, and a statement issued in the Synopsis of these reports by the Assembly of First Nations states:

> "The most basic finding of the 'population health' research is that socio-economic conditions and the social and physical environments are crucial in determining people's health. Social inequalities produce differences in health status, so that the poorest people with the least power consistently have worse health." (Assembly of First Nations, 1999, p.12).

The health status of a population most often is measured by quantitative indices, such as: life expectancy at birth, mortality rates, potential years of life lost, and morbidity rates. If health care is provided without addressing the determinants of health that lie outside health care, quantitative measures of the health status of a population are less likely to improve, and morbidity or utilization measures may show declining health status. The Lalonde Report of 1974 established the framework for key factors or health fields that determine health status. These factors were examined and established as the framework for a population health approach by the federal and provincial governments in 1994 (Federal/Provincial/Territorial Government Advisory Committee on Population Health, 1994). Some of the determinants of health include: (Regional Health Survey, AFN, 1999; Health Reports, Statistics Canada, 1999; F/P/T Advisory Committee on Population Health, 1994):

- socio-economic factors (employment, education, income and social status);
- social factors (early childhood development, social supports, and control over ones own life);
- lifestyle factors (nutrition, exercise, weight, smoking and alcohol use);
- emotional and spiritual factors (stress levels, coping skills and exposure to trauma);
- genetics; and
- health care services.

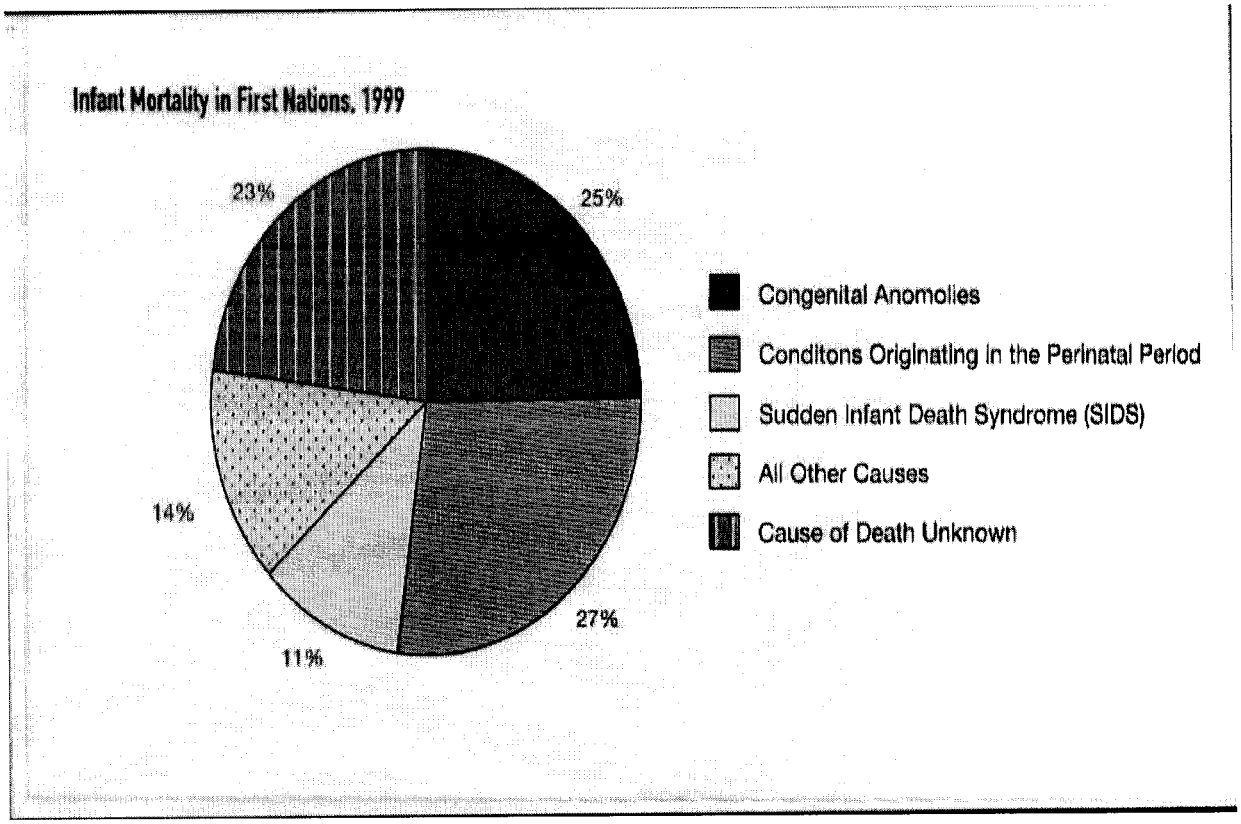
When measuring health status, measures of life expectancy and mortality rates can be associated with, and may be affected by, other factors such as unemployment and level of education (Statistics Canada, 1999). The Federal/Provincial and Territorial Advisory Committee on Population Health (1994) recognized that, in addition to health services, the key determinants of health included "our living and working conditions, economic well-being, and personal sense of control over and skills for coping with the challenges and stresses of everyday living". (p. 38) The documented effects of these social, economic and attitudinal factors re-focused the need to address inequalities in health status in a collective and comprehensive way.

2.2.1 Premature Mortality Rate

The premature mortality rate (PMR) measures the rate of premature death. Populations with a high PMR tend to have poor overall health and experience a greater burden of illness. While PMR is a good indicator of overall health status; as indicated, determinants of health such as low income, low education and high unemployment rates may affect the wellbeing of a population and have an effect on their health. Canadian First Nations have higher mortality rates than other Canadians. From 1986 – 1990, infant

mortality rate was 13.8/1000 compared to all Canadian infants at 7.3/1000. In Manitoba, infant mortality rates for First Nation people range from 2.1 – 2.9 times higher than the Manitoba rate for non-First Nation people (College of Physicians and Surgeons, 2003).

Figure 4: Causes of Infant Mortality



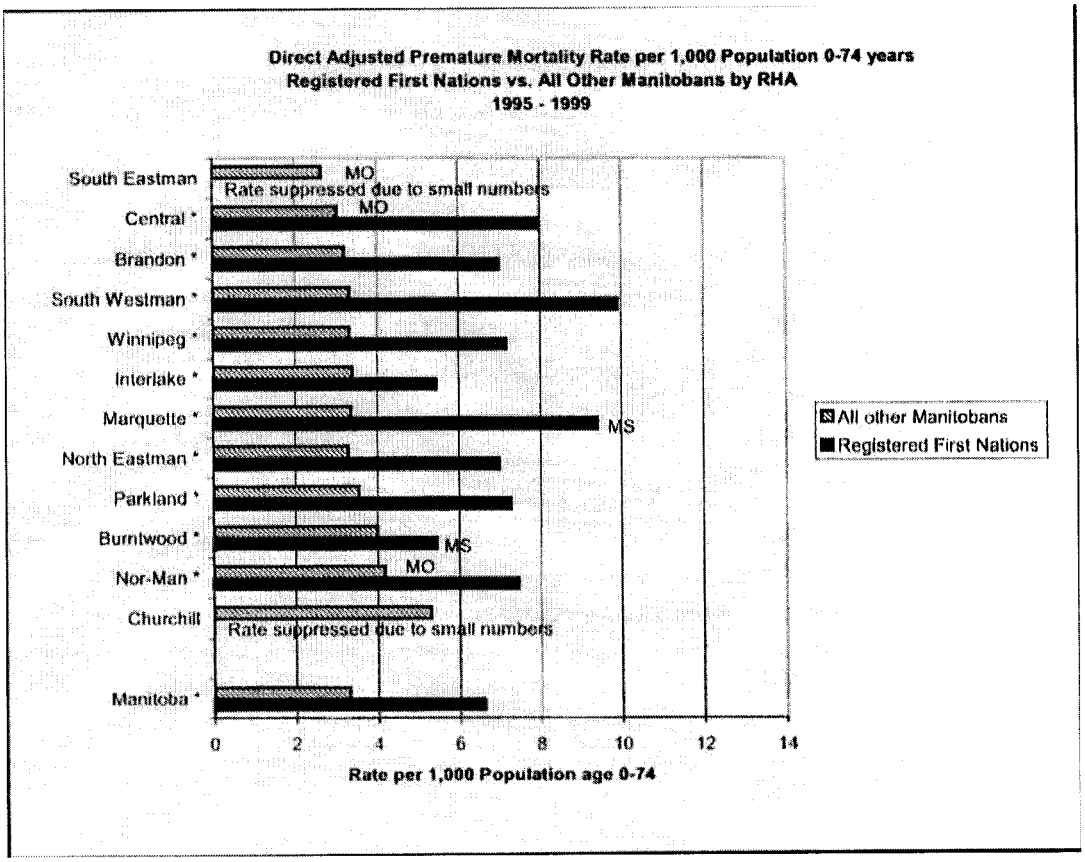
Source: Health Canada, A Statistical Profile of the Health of First Nations in Canada. FNIHB.

For First Nations males in 1979 – 1983, the mortality rate was 1.7 times higher for all males, and 1.9 times higher for all females (MacMillan et al, 1996). A recent study –'Health and Health Care: Manitoba's First Nations' by Martens et al, found that the Manitoba First Nations population had double the PMR of other Manitobans.

The PMR was elevated for First Nation people living on and off reserve, despite area of residence, and despite living in regions that have the best overall health status in

the province. Some regions with the best overall health status had First Nation populations with the poorest health status (Figure 5)(Martens, 2001).

Figure 5: Premature Mortality Rates

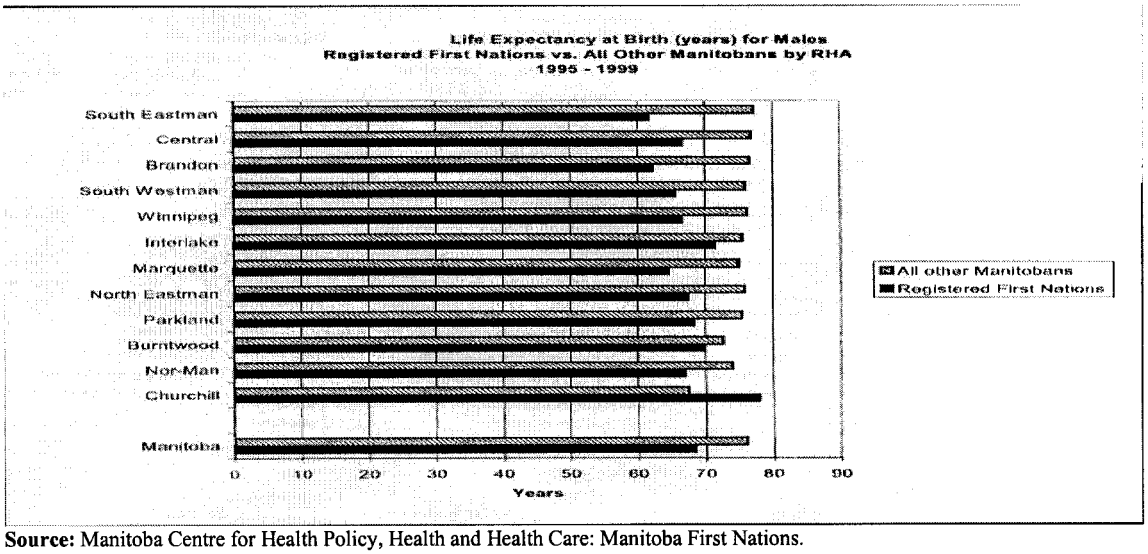


Source: Manitoba Centre for Health Policy, Health and Health Care: Manitoba First Nations.

2.2.2 Life Expectancy

Life expectancy is the expected length of life from birth. Aboriginal populations have had a lower life expectancy than all other Canadians for decades. This has improved by about ten years between the years of 1975 and 1995, however, there remain some significant differences between First Nation peoples and other Canadians (Statistics Canada, Health Reports, Winter, 1999; Health Canada, A Second Diagnostic on the Health of First Nations and Inuit People in Canada, 1999).

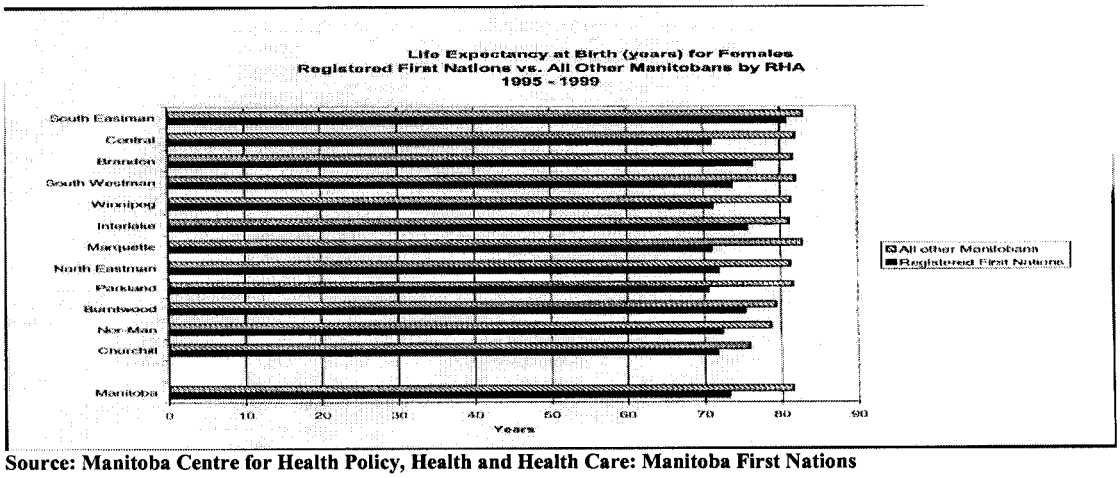
Figure 6: Life Expectancy – First Nation Males



Source: Manitoba Centre for Health Policy, Health and Health Care: Manitoba First Nations.

Life expectancy at birth is affected by many variables. Health regions with overall lower mortality rates for all causes of death, lower rates of unemployment, and higher levels of education will have individuals with an increased life expectancy. Life expectancy increases as the proportion of the population aged 25 – 54 with post-secondary degree increases, and as the rate of unemployment decreases (Statistics Canada, Health Reports, Winter, 1999, p.17).

Figure 7: Life Expectancy – First Nation Females



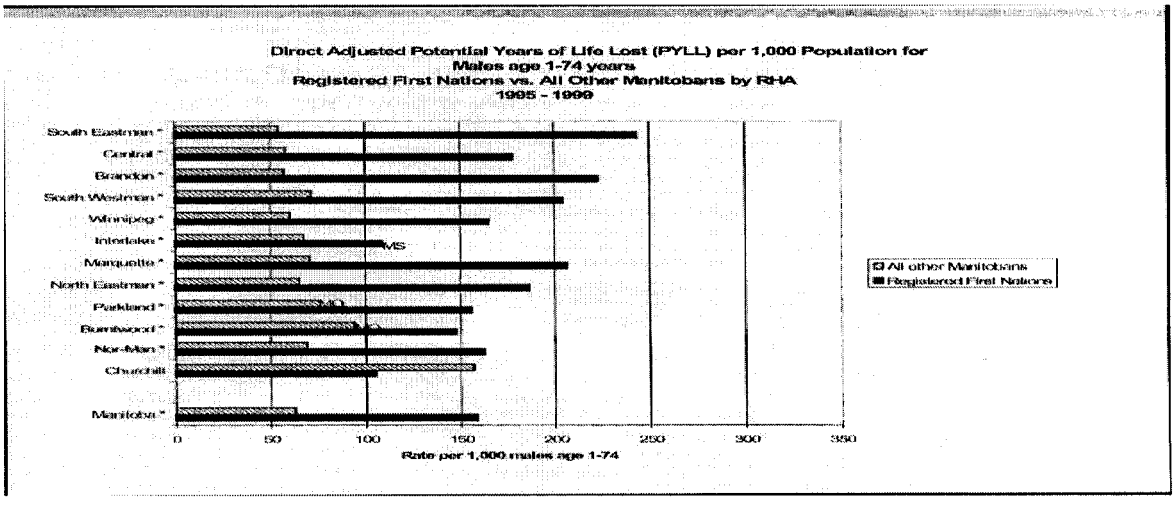
Source: Manitoba Centre for Health Policy, Health and Health Care: Manitoba First Nations

In Manitoba, First Nation people live approximately eight years less than other Manitobans (Martens, et al, 2001). Mortality rates in Manitoba are higher than the Canadian rate for most causes of death, particularly for deaths due to some chronic diseases, for infant mortality, for unintentional injury, and for suicide (Statistics Canada, Health Reports, Winter, 1999).

2.2.3 Potential Years of Life Lost

Potential Years of Life Lost (PYLL) measures the years of life lost when a young person dies. PYLL will be increased if a young population experiences a high death rate, and this usually occurs as a result of injury or disease causing death at a young age. The PYLL for First Nations has been consistently higher than that for all other Canadians. The leading causes of PYLL for First Nation peoples were injuries and poisonings. These rates were up to seven times higher than for all other causes (Health Canada, A Second Diagnostic on the Health of First Nations and Inuit People of Canada, 1999; Health Canada, A Statistical Profile on the Health of First Nations in Canada, 2003).

Figure 8: Potential Years of Life Lost – Males

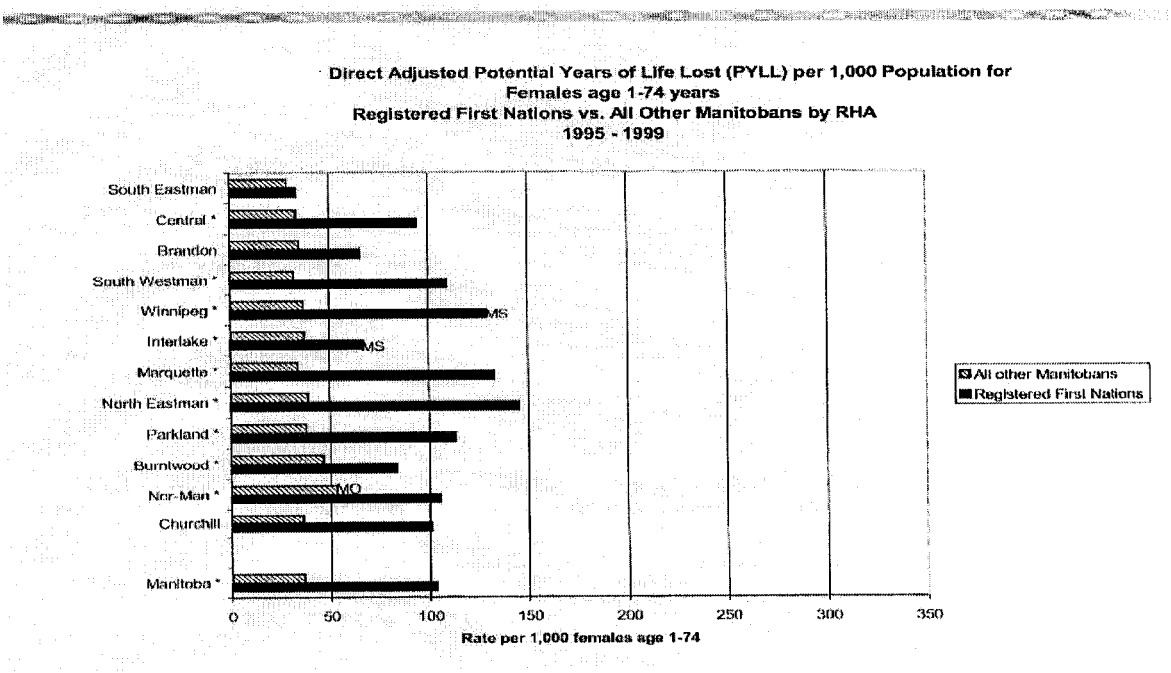


Source: Manitoba Centre for Health Policy, Health and Health Care: Manitoba First Nations.

The rate for First Nations Canadians in 1982 – 1985 was 2.8 times higher than the general Canadian population – 157.2/1000 vs. 56.5/1000. In Manitoba, the PYLL for First Nations is significantly greater than for other Manitobans. The PYLL for First Nations males is 2.5 times higher than the general population, and the rate for First Nations females is three times higher (Martens, 2001).

The First Nation population is a young population compared to Canadians generally, with the median age 13 years younger than the non-Aboriginal population (Statistics Canada, Census, Aboriginal profile, 2001). These statistics are concerning when viewing the implications for a rapidly growing population with a recognized increase in the incidence and prevalence of chronic disease. The number of Aboriginal seniors in Canada increased by 40% between 1996 and 2001 (Statistics Canada, Census data, 2001)(See Figure 2).

Figure 9: Potential Years of Life Lost – Females



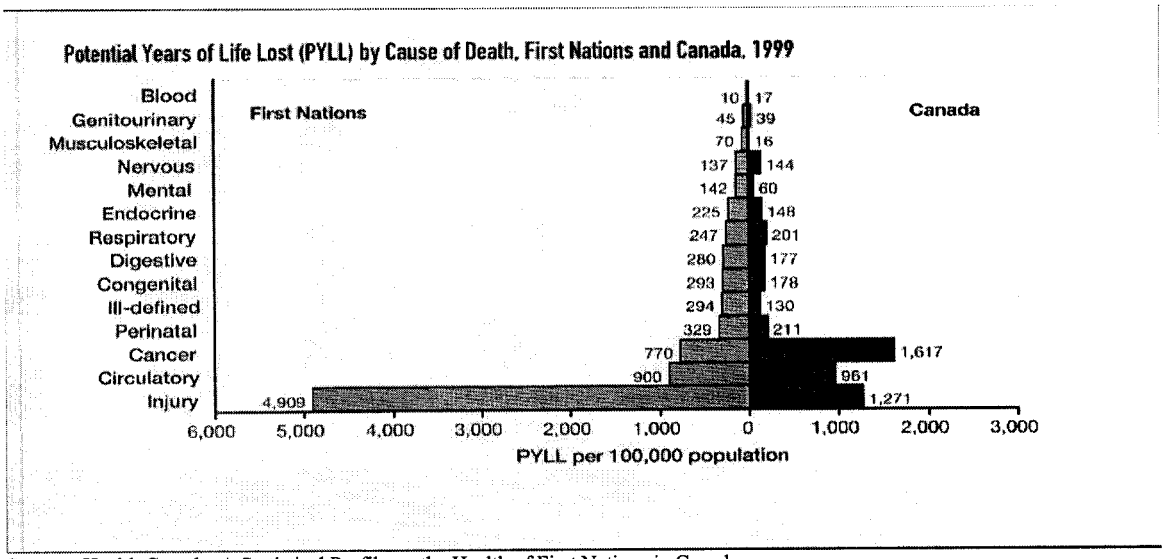
Source: Manitoba Centre for Health Policy, Health and Health Care: Manitoba First Nations.

The incidence and prevalence rates of diseases, such as diabetes, circulatory and respiratory diseases, and some cancers, is increasing in First Nation people (Health Canada, A Second Diagnostic, 1999; Manitoba Health, Aboriginal People in Manitoba, 2000; Martens, 2001). As the First Nation population ages, morbidity and mortality due to chronic diseases will continue to increase.

In addition, First Nation peoples experience higher rates of injuries, poisonings, and suicide. The rates of suicide for First Nations youth age 15 – 24 are significantly higher. The rates of suicide for First Nation male youth are five times higher than male youth nationally, and the rates of suicide for First Nation female youth are eight times higher than the female youth nationally (CICH, 2000).

The Manitoba study by Martens et al. using health care utilization data from claims files, cited not only excessive mortality and morbidity in First Nation people overall, but a PYLL rate that indicates that younger First Nation people are dying in greater numbers than other young Manitobans. The emergence of a significant burden of illness secondary to chronic conditions is established as well. The epidemiological overlap of infectious and chronic disease in First Nation peoples imply a need to enhance and better co-ordinate health services for this population in order to reverse this trend.

Figure 10: Potential Years of Life Lost – First Nations vs. Canadians



Source: Health Canada, A Statistical Profile on the Health of First Nations in Canada.

2.3 The Historical Context of Health Care in Canada – all Canadians and First Nation Peoples – Legislation, Policy Development, and Service Delivery

Health care delivery for First Nation peoples has been tied to the historical relationship between First Nations and government. This has been described as a fiduciary, or trust relationship, in that the federal government has a duty to ensure that it acts in the good faith and best interests of the Aboriginal (First Nation) peoples. The provision of health services to First Nation peoples (or Treaty, or status Indians – see Footnote 1) in Canada has traditionally been the responsibility of the federal government under Canada's Constitution.

This section of the literature review will provide background information on the legislation and policy development, both federal and provincial, which is relevant to the establishment of the current health service delivery system for First Nation peoples in Canada. Reference will be made to historical legislation and policy that is established for health services development for all Canadians, and how this has affected the evolution of health services delivery.

2.3.1 Legislative Background

In the Royal Proclamation of 1763 (Appendix 2), the British Parliament acknowledged Aboriginal nations, and stated that the "Indians are under the protection of the Crown" (Craig, 1992; Frideres, 1988). The British North America Act (BNA Act) (Appendix 3), of 1867 gave legislative authority to Parliament (the federal government) for "Indians and lands reserved for Indians". The provision of health and social services became the responsibility of the provincial governments (Craig, 1992; Canadian Medical Association, (CMA), Bridging the Gap, 1993; Postl et. al, 1988; MacMillan, et. al., 1996; Young, 1984). The Indian Act of 1876 assigns the legislative authority to the federal

government for jurisdiction over Indians and Indian lands. Neither the BNA Act nor the Indian Act clarifies the expectations for health care provision for First Nations people, and this continues to be subject to debate and negotiation today. Treaty 6 (Appendix 4), signed in 1876 between the Cree of Alberta and Saskatchewan, and Parliament; included a Medicine Chest Clause that states that:

> "In the event hereafter of the Indians...being overtaken by any pestilence, or by a general famine, the Queen...will grant to the Indians assistance...sufficient to relieve them from the calamity that shall have befallen them.
>
> A Medicine chest shall be kept at the house of each Indian Agent for the use and Benefit of the Indians at the direction of such agent" (Morris, 1880 – reprint of 1880 edition, 1991).

Reference to a medicine chest was not made in any other Treaty. Discussions involving the provision of medicines and medical services were referenced in the documents detailing the negotiation proceedings for Treaties 7, 8, 10 and 11, but were not included in the actual Treaties (Young, 1984; Craig, 1992). First Nation people maintain that this statement in Treaty 6 can be interpreted as establishing the federal government responsibility for health services for native people. Young (1984) summarizes the two legal cases in Canada which defined the terms of the Medicine Chest clause:

1. In the *Dreaver* vs. *R* case of 1935, the courts interpreted this to mean that "all medicines, drugs or medical supplies which might be required by the Indians...were to be supplies to them free of charge."; and
2. In the *R* vs. *Johnston* case of 1966, the judge declared that "The Indians are entitled to receive all medical services, including medicines, drugs, medical supplies and hospital care free of charge. Lacking proper statutory provisions to

the contrary, this entitlement would embrace all Indians within the meaning of the Indian Act, without exception." (cited in Young, 1984, p. 258)

The federal government has never accepted that health care is a treaty right. There continue to be ongoing disputes between federal and provincial governments regarding the jurisdictional responsibility for the funding and provision of health care services for First Nation peoples (CMA, 1993; Young, 1984; Craig, 1992; Frideres, 1988, Romanow Commission, 2002).

Table 1:	**First Nation Health Services in Canada and Manitoba – Legislative Background**	
1763	Royal Proclamation	'Indians under the protection of the Crown'
1867	British North America Act	'Indians/Indian lands – federal responsibility'
1876	Indian Act	
1876	Treaty 6	Medicine Chest Clause
1935	*Dreaver* vs. *R*	'drugs free'
1944	Department of Health and Welfare	Establish federal health department
1957	Hospital Insurance & Diagnostic Act	
1962	Medical Services Branch established	
1964	Manitoba – Agreement between Health Canada and Province of Manitoba	
1966	*R.* vs. *Johnson*	Meaning of the Medicine Chest
1966	Medical Care Act	
1982	Constitution Act	
1984	Canada Health Act	

Adapted from Young, 1984.

The Constitution Act of 1982 reaffirmed existing aboriginal and treaty rights (Appendix 5) despite the intentions of the White Paper of 1969 (officially called "The Statement of the Government of Canada on Indian Policy"). The White Paper proposed a policy of assimilation that would have abolished the special status of Indian people in Canada by repealing the Indian Act. The Constitution Act of 1982 did not address the jurisdictional ambiguity that exists for First Nation peoples in the areas of health and social services.

In actual fact, until the final moments, the Constitution Act of 1982 came very close to excluding all reference to Aboriginal and First Nation rights.

2.3.2 Evolution of Health Service Delivery

Health care for Aboriginal people was initially provided by missionaries, and by the Hudson's Bay Company, as well the Royal Canadian Mounted Police. Itinerant services, which were provided by the federal government, were primarily developed to contain epidemic disease. Individual physicians collaborated with Indian Agents in delivering primary care services throughout the country before and after the inclusion of the Medicine Chest Clause in Treaty Six. A co-ordinated approach to health services did not exist until 1904 when Dr. Peter H. Bryce was appointed as chief medical officer for the Department of Indian Affairs (Young, 1984; Craig, 1992; Waldram et al, 1995).

Dr. Bryce made efforts to address the diseases affecting the Indian people; particularly tuberculosis, which was ravaging the inhabitants of residential schools. Dr. Bryce' concerns were not addressed, and his efforts to improve the health of the Indian people were met with inaction (Young, 1984; Craig, 1992). Although he did not retire until 1921, Dr. Bryce' advice was not solicited after 1913. Bryce conceived of the concept of the nurse visitor service to residential schools and reserves as a complement to the itinerant physician services. However, this service was not implemented until after his retirement in 1922. The nurse visitors performed health education and public health functions.

Col. E. L. Stone was appointed medical superintendent for Department of Indian Affairs in 1927. A formal Medical Branch was created within Indian Affairs after his arrival. The nurse visitor concept was expanded upon when the first nursing station was

established in 1930 in Fisher River, Manitoba. The nursing station practice model combined health promotion and education with primary health care and some cottage hospital activities.

In 1936, the Department of Indian Affairs was rolled in to the Department of Mines and Resources and became the Indian Affairs Branch. Medical services remained in this Branch until the Department of National Health and Welfare Act was passed in 1944 and Indian Health Services became part of this department.

The newly established Department of National Health and Welfare had assumed responsibility for health services for Indian people in 1945, and initially administered the Indian and Northern Health Services Directorate. The Medical Services Branch was established in 1962. Its duties included the provision of direct service for the categories which fell outside the provincial jurisdiction for health care as defined in the Constitution (BNA) Act of 1867: Civil Aviation Medicine, Public Service Health, Indian Health, Northern Health, Quarantine, Immigration and Sick Mariners Service (Young, 1984; Craig, 1993; Blake, 1995; McGilly, 1993). The major activities of Medical Services Branch, however, centred around Indian health service delivery. Responsibility for service provision to First Nation and Inuit people was established on a regional and zonal basis. As the needs increased, and service provision became more comprehensive, changes occurred within the directorate over the years.

2.3.3 Development of Universal Health Care

The Government of Canada passed two Acts, in 1957 and 1966, which would change the way health care services were delivered for all Canadians. Federal legislation, in the form of the "Hospital Insurance and Diagnostic Services Act" of 1957 and the

"Medical Act" of 1966; resulted in the federal government providing the provinces 50% of the annual costs of basic insured health services (Taylor, 1987; Blake & Keshen, 1995; Health and Welfare Canada, Organization of Health Services to Indian People of Manitoba, 1986). The Royal Commission on Health Services in 1964 resulted in the legislation leading to universal health care insurance. The provinces accepting obligation to support this contribution agreed to insure basic hospital and medical services, and to meet the conditions of universality, comprehensiveness, accessibility, portability and public administration. The federal government agreed to finance the provinces for 50% of the health care costs under this arrangement.

Following the implementation of universal health care; by 1971, all Canadians were eligible for free health services which included hospital and physician services. Medical costs were borne by the provincial governments' health plans. The federal government became concerned about their rising costs attributed to health care, and provinces were concerned about the lack of flexibility in the way health care priorities were defined (Manitoba Budget Papers, 2002). In 1977, a new arrangement between governments with the Established Programs Financing (EPF) transfer of funds allowed greater flexibility to meet special needs, and could apply to extended health care in nursing homes and drug-benefit plans. The EPF was block funding that included funding for post-secondary education, hospital and medical care, and the Canada Assistance Plan (CAP) included funding for other social programs.

The new Canada Health Act of 1984 replaced the Hospital Insurance and Diagnostic Act (1957) and the Medical Act (1966). The Canada Health Act set out the program criteria and conditions for payment of the federal contributions to the provinces

for insured health services and extended healthcare services. It held to the principles of medicare, in that the criteria for eligibility for the full costs of the contribution include:

- Public administration: the program must be administered by a public authority accountable to the provincial government;
- Comprehensiveness: the program must cover all necessary hospital and medical services, and surgical-dental services rendered in hospitals;
- Universality: one hundred per cent of provincial residents must be entitled to insured health services;
- Portability: the waiting period for new residents must not exceed three months; insured health services must be made available to Canadians temporarily out of their own province at no extra charge to patients; payment for services out-of-province to be paid for by the home province at host province rates; payment for services out-of-country to be at home province rates;
- Accessibility: reasonable access to insured health services is not to be precluded or impeded, either directly or indirectly, by charges or other mechanisms; reasonable compensation must be made to physicians and dentists for providing insured health services; adequate payments must be made to hospitals in respect of insured health services.

The emerging practice of implementation of user fees and extra billing was halted with the Canada Health Act, as provinces were forced to comply with the federal governments' position in order to access federal funds. However, an increasing federal debt resulted in gradual cuts to funding of the EPF. In 1982-83, the federal government began to make adjustments to the EPF and CAP funds, and by 1998-99, the federal share had been cut by half. The Canada Health and Social Transfer (CHST) was introduced in 1996/97 and included block funding for education, health and social services. (Lazar et al, 2002; Braen, 2002, Manitoba Budget Papers, 2002). Some increase of this funding occurred in 2000, but it did not include full restoration of the fund.

With the development and implementation of universal health care plans, services to First Nation people became more complex. In Manitoba, the province assumes

responsibility for physician and hospital services for all residents, including First Nation peoples. Physician services to remote areas are organized and financially subsidized by the federal government to ensure access to service. Community health services, including public health services, continue to be provided by the federal government on reserve.

2.3.4 A Federal/Provincial Approach

In Manitoba, the Canada-Manitoba Agreement of 1964 (Appendix 1) established a Memorandum of Agreement wherein a federal-provincial willingness to assume primary responsibility for health care delivery for each others clients in specific communities was established. The 1964 Memorandum of Agreement (MOU, 1964; Health and Welfare Canada, 1986) designates that:

1. communities with a majority treaty population to federal jurisdiction for the provision of clinical and community health services; and
2. communities with a majority non-treaty population to provincial jurisdiction for the provision of clinical and community health services.

Health reform has resulted in the establishment of regional health authorities provincially. Health transfer is similar in that First Nations communities assume the management of health service delivery within their respective geographic areas with established federal funding. The health transfer process has limitations in that it is based on existing funding, and existing programming defined by federal government priorities for First Nation peoples. This process of health reform has resulted in the re-profiling and re-prioritizing of regional and community needs. As a result, there are ongoing negotiations to develop alternative models of health care delivery which overcome the limitations of the system defined by the 1964 Agreement.

Throughout the evolution of health care delivery models, and the changing priorities for federal and provincial responsibilities in health care delivery, the federal government regularly indicated that they provided health services to Indian people as a matter of policy and goodwill:

> "There is nothing ...which places responsibility on the Minister for medical services to Indians and Eskimos, except the general responsibility the Minister has in respect of the public health of the people of Canada. In view of the general responsibility vested by the Indian Act in the Government of Canada....it has been the practice of (this Department) to undertake duties relating to the medical and hospital care of Indians, Eskimos, and other persons in the far North where such services are not otherwise available" (Department of National Health and Welfare, Canada, Annual Report, 1966 – cited in Young, 1984; p. 258).

Medical Services Branch provided health services for First Nation peoples through direct services in the North on a national level. In addition, non-insured health benefits that include coverage for benefits such as prescription drugs, dental services, vision care, medical supplies and equipment and medical transportation were provided for First Nation peoples through-out Canada. In Manitoba, in the 1964 Agreement, the responsibility for health service delivery for all residents of a community was borne fully by either the federal or the provincial government, based on geography and population.

2.3.5 Federal Policy Development

The initial Indian Act of 1876 had been drafted and formed without the involvement of Indian people, and subsequent legislation and policies have not involved them either. The White Paper in 1969 was such an example, and the recent drafting of the First Nations Governance Act (Bill C-7) in 2002 continues the practice of exclusion.

The White Paper of 1969, which proposed the removal of the special status of Indian people, and special services identified under the Indian Act, resulted in a quick

and angry response from First Nations. In response to this renewed federal attempt at assimilation, the 1970 Red Paper (published as *Citizen Plus*) put forward by the Alberta First Nations re-emphasized the federal responsibility for health care to First Nation peoples and asserted their plans to strengthen community control of their government run programs (Young, 1984). The Red Paper referred to the concept phrased by the Hawthorn Report of the mid-1960's which pointed out:

> "...in spite of their miserable socio-economic conditions, Indians actually deserved better treatment from Ottawa than did other Canadians. Because of their Aboriginal title and treaty rights they should be treated as 'citizens plus.'' (cited in Miller, 1989, p. 223).

The Booz-Allen-Hamilton report, initiated by the Department of Health and Welfare as a review of Indian health services, made several recommendations for reorganization which included a focus on public and preventive health and community development.

Table 2: First Nation Health Services – Key Policy Documents

1964	Royal Commission on Health Services
1964	Booz-Allen-Hamilton Report
1969	White Paper (The Statement of the Government of Canada on Indian Policy)
1970	Red Paper (Citizen Plus)
1974	Indian Health Policy
1978	Non-Insured Services Guidelines
1978	New Indian Health Policy
1980	Berger Report
1983	Penner Report
1988	Health Transfer Policy
1996	Royal Commission on Aboriginal Peoples

The 'Policy Directive' of 1978 on non-insured health benefits followed an initial draft of an Indian Health Policy in 1974 and resulted in a strong negative response by First Nations. The federal governments' current Indian Health Policy 1979 (Appendix

6) identified three essential supporting factors for future development of health services for First Nation peoples. They include: community development; confirmation of the special relationship between the federal government and the Indian peoples of Canada; and the full use of, and participation in, the Canadian health system by Native people. The Indian Health Policy acknowledges the federal governments' "legal and traditional responsibilities to Indians" defines the federal responsibility for First Nations health services. It further defines an increase in the financial and administrative responsibility of the provincial role in health care provision for First Nations (Indian Health Policy, Appendix 6; Comeau & Santin, 1990).

The Berger Report (1980) identified the matter of Indian health care as 'critical' and recommended that the federal government engages in consultation with First Nations to effect the design, management and control of health care services in their communities.

The Penner Report of 1983 (Report of the Special Committee on Indian Self Government) was commissioned to review self-government issues for First Nations. Although focused on self-government, it discussed the three critical areas of education, child welfare and health care in the context of the socioeconomic status of First Nation peoples. Gudmundson (1993) observes that the Report:

> "noted conditions of social disintegration and deprivation arising from the colonial treatment of Aboriginal peoples by the Government of Canada." [On-line: www.samkoma.com/thesis].

Gudmundson indicates that the Penner Report summary:

> "urged that jurisdiction over such areas as education, child welfare and health care was required to offset the problems of the past colonial treatment of Aboriginal peoples". [On-line: www.samkoma.com/thesis]

The Health Transfer Policy was established in 1988, with the intent to have First Nation communities assume the management of health services. It has allowed First Nations to assume responsibility for the delivery of community based health services on reserve.

The Royal Commission on Aboriginal Peoples involved extensive consultation with Aboriginal people and occurred over a five-year time frame. The final report was submitted in 1996, and contained numerous recommendations in the areas of health, education, justice, social services and governance. Included were recommendations on the need for resolution of jurisdictional issues. Few of these recommendations have resulted in definitive action.

Medical Services Branch became the First Nations and Inuit Health Branch in 1998, and continues to provide services for First Nations people on reserve; as well as non-insured health benefits for First Nations on and off reserve. The costs for these health services have continued to escalate as the First Nation population increases and the utilization rates increase (NIHB Annual Report, 2001/2002).

2.3.6 The Legacy of Unresolved Jurisdictional Issues

The federal government has demonstrated continuing reluctance in accepting the financial responsibility for health care for First Nations. Attempts to formally curb the expenditures of these services, including non-insured health benefits, have been made over the years always with resistance by First Nations (Young, 1984).

The increase in expenditures for non-insured health benefits is attributed to "increased population and utilization, increased benefit costs, inflation, and changes to provincial health care systems" (NIHB Annual Report 2001/2002, p. 9). The NIHB

Annual Report also indicates that the rate of growth in program expenditures declined over the last ten years, from 20.9% to 9%, as a result of NIHB management initiatives. (p. 19)

A heavy burden of chronic disease requiring extensive diagnostic procedures and interventions and expensive medications for medical management has resulted in escalating medical transportation and prescription drug costs. Through the commitment by the federal government to ensure access to medical services, and an adherence to standards of care in disease management; referrals to specialist consultants in urban areas has increased the costs of medical transportation exponentially. Efforts to curb the non-insured health benefits costs and to limit expenditures within an envelope system by regions have been unsuccessful in some areas, as costs continue to escalate for the reasons cited above.

The limits placed on available benefits, and difficulties in accessing benefits have resulted in a situation that is described by some as cuts in service, and by others as an off-loading of responsibility to provincial governments. Policy changes at the federal level in health care for First Nation peoples almost always affects the level of responsibility of the provincial government. The federal governments' refusal to provide medical transportation costs to off-reserve First Nation peoples resulted in the provincial government of Manitoba picking up the responsibility through the Northern Patient Transportation Program. In the past, Manitoba Health would pay for the initial transportation costs for off reserve First Nation peoples in northern Manitoba, and would invoice Health Canada throughout the year. This commitment to pay initial transport costs was honored until 1998, when the Regional office of First Nations and Inuit Health

Branch would no longer accept responsibility for this population (Communication, FNIHB to Manitoba Health, 1998).

The responsibility for health care and health care delivery for First Nations continues to be a political football, and while this is being passed back and forth, the health status of First Nation peoples remains the lowest of any segment of the population. While the federal government does not acknowledge a mandate for full responsibility for program delivery, they have not established a process to work with the provincial and First Nation governments in establishing a protocol that addresses the needs of First Nation peoples. The lack of clarity on defined areas of jurisdictional responsibility between federal and provincial governments, and the firm belief by First Nation peoples that health is a treaty right; is an ongoing issue.

2.4 Jurisdiction for First Nations Health

As indicated in the historical overview, the provision of health services to First Nation peoples has traditionally been a federal responsibility. The British North America Act of 1867 gave the federal government authority over 'Indians and lands reserved for Indians', while health and social services were designated as the responsibility of the provinces.

The Medicine Chest Clause in Treaty 6 has been interpreted by First Nations as evidence of the obligations by the federal government, under treaty, for the health care for First Nation peoples. Although Treaty 6 is the only document which contains a medicine chest clause; government documents show that similar promises were made by the treaty commissioners during the negotiation of Treaties 7, 8, 10 and 11 (Craig, 1992; Young, 1984).

The question of who holds the responsibility for providing and paying for health services for First Nation peoples has been raised repeatedly over the years. There have been court challenges to the treaty right to health services for First Nation peoples, with varying results. Some of the cases which involved the billing of Aboriginal people for services, such as physician and hospital services, are no longer as critical since the implementation of the Canada Health Act, and universal health care for all Canadians. Consistently, First Nation peoples have maintained that the federal government has a jurisdictional responsibility for the provision of health services for their population.

Jurisdiction is defined as "the legal power or authority to act in a particular way", while responsibility is defined as 'the quality or state of being responsible, as a moral,

legal or mental accountability – reliability, trustworthiness" (Craig, 1992, p. 2). Craig further states that:

> "jurisdiction is the legal power to act or to legislate, while responsibility is the legal or moral obligation to act. Having jurisdiction to legislate over a certain matter does not necessarily mean that Parliament has responsibility for that matter." (p. 2)

An extensive legal review of jurisdiction and Aboriginal health by Craig in 1992 examined federal and provincial law as it pertained to health, and to Aboriginal health. Key legislation included the Constitution Act of 1867 (BNA Act) and the Constitution Act of 1982. The Indian Act is relevant in its jurisdiction for 'Indians and lands reserved for Indians'. The Canada Health Act, in conjunction with the provincial and territorial health legislation and insurance plans form the basis for interpretation of eligible insured health services for all Canadians. A summary of the relevant legislation in the legal framework for Aboriginal Health is presented in Table 3.

Table 3: Legal Framework for Aboriginal Health

Constitution Act, 1867, federal government responsible for 'Indians, and Lands reserved for the Indians'
Constitution Act, 1982, recognizes and affirms existing Aboriginal and treaty rights without defining
Indian Act, 1876
Canada Health Act, 1984
Provincial and territorial health insurance plans
Provincial and territorial health legislation

Adapted from Craig, 1992.

2.4.1 Federal/Provincial Jurisdiction in First Nations Public Health

Reviews of several provincial court challenges to provincial jurisdiction over time were summarized, from a legal perspective, in Craig's study. She concluded that:

> "It is clear that the provinces have jurisdiction over hospitals; that they have jurisdiction over public health...that they can regulate medical professionals...it is also evident...that there is room for provincial health legislation to co-exist with compatible federal legislation." (p. 59)

The conclusion from this review is that both federal and provincial governments have jurisdiction over health (Craig, 1992). Both levels of government have been given authorization to take action in the field of public health within their respective jurisdictional areas (Braen, 2002). There has been uncertainty over the jurisdiction for public health in First Nation communities. Craig's review included examination of the Rowell-Sirois Commission Report, which commented on public health as a concept that would not have been conceptualized in 1867 when the BNA Act was drafted. They recommended that:

> "Provincial responsibilities in health matters should be considered basic and residual. Dominion activities on the other hand, should be considered exceptions to the general rule of provincial responsibility, and should be justified in each case on the merit of their performance by the Dominion rather than by the Province...Dominion jurisdiction over health matters is largely, if not wholly, ancillary[2] to express jurisdiction over other subjects..." (as cited in Craig, 1992; p. 55).

Craig concluded that:

> "Aboriginal health may have a 'double aspect', amenable to legislation by both levels of government, with the doctrine of paramountcy[3] applying in the event of an inconsistency." (p. 55)

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[2] Webster's dictionary defines *ancillary* as "subordinate, or subservient". (p. 9) It is described by Craig as: 'Provisions of a Dominion State which directly intrude upon provincial classes of jurisdiction and which, standing alone, would be incompetent to the Dominion, may nevertheless be valid as being necessarily incidental to full-rounded legislation upon a Dominion subject-matter or to the effective exercise of an enumerated Dominion power, or to prevent the scheme of an otherwise valid Act from being defeated.' (p. 46)

[3] Craig (1992) states that: "The paramountcy doctrine was developed to address situations where the court had applied the double aspect doctrine so that both the federal and provincial laws are valid, and yet they are inconsistent. Both states cannot be allowed to stand if they require the same group of people to do things in inconsistent ways. Thus, in situations where a federal statute and a provincial statute are both validly enacted and yet they are inconsistent, the doctrine of paramountcy applies, and the federal statute prevails." (p. 49)

This is interpreted to mean that since both federal and provincial laws are valid, but they are inconsistent; they cannot both be allowed to stand, and therefore the federal statute would prevail (Braen, 2002; Craig, 1992).

The provinces have exclusive jurisdiction over some aspects of health, while there is concurrent jurisdiction over others. The federal government has some jurisdiction for public health, and so do the provincial governments. The division of authority over public health between the federal and provincial governments has resulted in a "non-system" (as cited in Craig, 1992, p. 56). Challenges of the policy in case laws have upheld the rights of the provincial legislation to regulate the practice of public health, indicating that the federal and provincial legislation can co-exist with compatible federal legislation (Craig, 1992).

Health Canada has always funded public health services and programming on reserve, although they have not officially acknowledged responsibility for this service prior to the 1979 Indian Health Policy. The legislative authority for the provincial Public Health Act on federal/reserve lands has been an ongoing problem in public health practice. Neither the provincial nor federal level of government has made conclusive decisions to accept or assume this responsibility. Based on the case law decisions cited by Craig, it may be assumed that the provincial government does have the right to regulate the practice of public health on federal lands. Without clear policy directives at the federal and provincial levels, in Manitoba, the provincial government has not accepted responsibility for public and environmental health services on reserve, except in the communities designated under the 1964 Agreement (Memo, Chief Medical Officer of Health, Manitoba Health, 2003).

2.4.2 The Indian Act vs. the Constitution Act in Health Jurisdiction

The Constitution Act assigns the authority for making laws to either Parliament or the provinces in most matters, however, nowhere in the Constitution is there reference to authority for laws in health, health services or health care (Braen, 2002; Craig, 1992). Braen and Craig note that in *Schneider vs. the Queen,* the Supreme Court of Canada indicates:

> "In sum, 'health' is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question." (as cited in Craig, p. 62; cited in Braen, p. 3).

While legislation over health frequently results in review on a case by case basis as to the applicability of federal or provincial statutes; clarification around the legislation for health as it pertains to 'Indians and lands reserved for Indians' has not been addressed. The Indian Act primarily addresses property and band governance (Department of Indian Affairs and Northern Development, the Indian Act: A Simplified Version, 1982; Indian Act, 1876). It gives the government the right to make regulations for, among other things, 'the provision of medical and health services for Indians...and to provide for sanitary conditions in private and public places on reserves' [Indian Act, s. 73(1)].

The Indian Act also gives Bands the right to make Band by-laws and to provide for the health of residents on the reserve, and to prevent the spreading of contagious and infectious diseases (s. 81 (1)). These provisions would ordinarily fall within provincial legislative jurisdiction. Based on the Indian Act, the federal government has the right to

exercise legislative authority over Indians in sectors where it cannot exercise legislative authority over non-Indians. This is as a result of the ancillary (subordinate) role of the provincial legislation to the federal power under the Constitution Act.

Can provincial laws be applied to 'Indians and lands reserved for Indians'? It is clear that provincial laws apply to Indians as long as it does not affect Indian status. Section 88 of the Indian Act reads:

> "Subject to the terms of any treaty and any other Act of the 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, 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 the Act."

Craigs' review on this area indicates, from case law reviews, that "provincial laws can apply to lands reserved for Indians as long as it is not in relation to the use of land by Indians" (Craig, 1992, p. 90). Provincial law would only apply "to the extent that they do not make provision for any matter for which provision is made by or under the Indian Act, and to the extent that they are not inconsistent with the Indian Act" (Craig, 1992, p. 93). In general, provincial laws of general application apply to Indians unless they impair Indian status in some way. Craigs' summary was that: "if a piece of valid provincial legislation that applies by virtue of section 88 is inconsistent with the Indian Act, or any order, rule, regulation or by-law made thereunder, it will not apply to Indians". (p. 99) Provincial laws therefore cannot impinge on treaty or Aboriginal rights without impairing Indian status, and would not be valid in that instance. Since there are few cases which address the applicability of provincial health legislation over

constitutional jurisdiction, this limits the ability to form general conclusions over which level of government ultimately has jurisdiction for Aboriginal health.

Craig indicates that, with First Nations health amenable to legislation by both levels of government, the courts may be obliged to assess the activities involved in health care delivery to determine who has jurisdiction over health. She summarizes the activities of a Band involved in delivering health services on reserve and participating in health transfer agreements as activities which may be services for Indians and lands reserved for Indians, and therefore, under federal jurisdiction. She also indicates, however, that:

> "It is firmly established that provincial laws of general application apply to Indians, and that the greater jurisdiction for health rests with the provinces." (p. 127)

The message is that, generally and specifically in situations of uncertainty, jurisdiction must be identified on an individual case by case basis. This uncertainty as to the clarity of jurisdictional responsibility through the historical legislative framework highlights the underlying causes of persistent jurisdictional ambiguity in health services.

2.4.3 Policy in First Nations Health

To date, other than the Health Transfer Policy, there have been no formal policy statements on First Nations health since the Indian Health Policy of 1979. The federal Indian Health Regulations, passed under the Indian Act, were revoked in January of 1992. The Indian Act made reference to the ability of bands to pass by-laws for specific situations, including health. The Indian Health Regulations required that:

> "Indians living on a reserve or following the "Indian mode of life" comply with all laws and regulations in force within a province relating to health

> or sanitation, except such laws or regulations as were inconsistent with Part I of the regulations." (cited in Craig, 1992, p. 12).

The Indian Health Regulations did not mention band by-laws, as does the Indian Act. Any band by-laws passed could not require Band members to do anything that was inconsistent with provincial legislation, and as a result, Band health by-laws were disallowed. Based on this practice, a recommendation was made to the Minister of Indian Affairs to repeal sections deemed to be unconstitutional. Rather than addressing those issues specifically, the Regulations were repealed in their entirety (Craig, 1992).

Provincial governments are obligated to provide comprehensive services for all residents, but will not assume or accept full financial responsibility for programs traditionally funded by the federal government. Provincial governments also cannot impose public policy that would be seen as interfering in the relationship between the federal government and First Nations'.

Recent changes to regional federal policies on health services have resulted in a shifting of financial responsibility for some benefits for First Nation people, particularly for those First Nation people living off-reserve. Since the delivery of health services for all provincial residents is a provincial responsibility, the provinces should be aware of federal policy changes impacting specific services provided for First Nation people.

Unilateral decisions by federal programs resulting in policy changes have not allowed for sufficient dialogue between federal, provincial and First Nation governments to adequately assess either the impact on provincial government expenditures, or the long-term impacts on First Nation communities undergoing health transfer. The program decisions on changes in eligibility for benefits will have limited expenditures for federal

programs, but will have a resultant shift to either the provincial or First Nation governments. The provision of sufficient funding support to the provinces for off-reserve First Nation people who are obliged to seek these services under provincial programs likely will not have occurred.

Expenditures for programs, such as medical transportation and income support for off-reserve individuals, have been shifted from the federal government to the provincial government through programs like Manitoba's Northern Patient Transportation Program (Correspondence, FNIHB to Manitoba Health, 1998; Applying Manitoba's Policies for Aboriginal People Living in Winnipeg, 1993). Formal correspondence has been exchanged between First Nations' and the provincial governments to share information on the health care costs to First Nations that have been shifted from the federal government to the provincial government through benefit and program revisions (Mr. David Newmann, Correspondence, 1998).

2.4.4 Implications for First Nations Health Care in Manitoba

Manitoba has the highest proportion of First Nation people of all Canadian provinces (Statistics Canada, 2001; Working in Partnership, Manitoba Policy Statement, 1999). It is recognized that Aboriginal people utilize health care services more than non-Aboriginal people, have a greater burden of illness than non-Aboriginal people, and utilize more days of hospital care than non-Aboriginal people (Martens et al, 2001; Health Canada, 1999; Aboriginal People in Manitoba, 2000). To date, the Manitoba government, as other provincial governments, has not been invited to participate in formal discussions between First Nations and the federal government (Weaver, 1985; Working in Partnership, Manitoba Policy Statement, 1999). Efforts have been made to

establish partnerships with First Nations' in a manner that will not affect the historical relationship with the federal government (Correspondence: Manitoba Government and AMC, 1998; Joint Romanow Working Group Presentation, 2003). The Manitoba government has not been involved in debates on the 'treaty right to health' and jurisdictional responsibility between the federal and First Nation governments.

In Manitoba, First Nation peoples and the provincial government, and most recently, the federal government, have begun a collaborative process to begin to address the recommendations of the Romanow report (Correspondence, AMC Grand Chief – Federal Minister of Health, 2003; Romanow Joint Working Group Terms of Reference, 2003; Correspondence, Deputy Ministers of Manitoba Government and AMC, January, 2003; Assembly of Manitoba Chiefs General Assembly Resolution, January 2003; AMC General Assembly Resolution, 1997). In the past, dialogue did not routinely occur between federal and provincial governments with regard to the funding of programs for Aboriginal people. The result was partial duplication of services and programs, and poor access to these services as a result of a lack of co-ordination between service providers (Hanselmann, 2003).

The implications for health care spending in Manitoba is that of increasing costs with routine shifting of responsibility for program expenditures from the federal to the provincial arena, with an Aboriginal population that is increasing in size. There are minimal community supports to assist in the shift from acute care (hospital based) to community based services such as home care and other support services. The ongoing transfer initiative has brought the issue of jurisdictional responsibility to the forefront, particularly in the areas of supportive community based and public health services. As

more communities assume transfer of the control of health service delivery, First Nations are dealing with the issue of co-ordination of services across jurisdictions. Provincial laws are generally applicable to First Nation communities unless there is operational conflict with the Indian Act or regulations or by-laws under the Indian Act. The ability of federal, provincial or First Nation employees to uphold provincial legislation on federal/reserve lands has not been clarified.

Jurisdiction for health services remains ambiguous. Although dialogue has improved, a commitment to resolution of outstanding issues is necessary to improve the co-ordination and delivery of services for First Nations. The jurisdictional responsibility for provision of health care services to First Nation peoples in Canada continues to be debated.

2.5 First Nations Health Issues

The persistence of poor health status in First Nation peoples has been of concern to First Nation peoples, to policy makers and to health care administrators in government for some time. Numerous round tables, health forums, commissions and other forums for dialogue have occurred over the last two decades. These discussions have included government representatives from all three levels of government, community representatives, health care service providers, and representatives of Aboriginal organizations involved in health and social services delivery. The health forums all had, as their primary focus, the issue of how to develop strategies that would begin to address the health care needs and elevate the health status of Aboriginal people. The need to address jurisdictional issues was identified as a requirement for enhanced co-ordination of services to First Nation peoples.

A literature review completed by the Winnipeg Regional Health Authority, in its Continuum of Care Strategy for Aboriginal Health Services summarized the findings in key documents from these health forums and studies. They identified recommendations which required the resolution of jurisdictional issues to improve the health and health services for Aboriginal people (Appendix 7). Health issues of primary concern were in the areas of:

- accessibility to services;
- health status and the determinants of health that impact on health status; and
- the governance and planning of health care services (WRHA Continuum of Care Strategy, 2001).

Within these primary areas of accessibility, health status and governance issues key recommendations focused on:

- the need to address jurisdictional areas;
- the need for integration of services;
- the need for collaboration between service providers; and
- the need to respect the Aboriginal right to plan, govern and deliver services for Aboriginal people that were culturally competent and grounded in traditional values.

Jurisdictional issues remain key to advancing a comprehensive health care plan for First Nation peoples, with the full involvement of First Nation people.

The goal of the Indian Health Policy of 1979 (Appendix 6) was "to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves". As indicated, the 'pillars' of the Indian Health Policy included community development; confirmation of the special relationship between the federal government and the Indian peoples of Canada; and the full use of, and participation in, the Canadian health system by Native people. Historically, Native people had very little input in to the delivery of health care under the established system. The third pillar of the Indian Health Policy, pertaining to the Canadian health system, states that it:

> "is one of specialized and interrelated elements, which may be the responsibility of federal, provincial, or municipal governments, Indian bands, or the private sector...the most significant federal roles in this interdependent system are in public health activities on reserve, health promotion, and the detection and mitigation of hazards to health in the acute and chronic disease and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community...the federal government is committed to maintaining an active role in the Canadian health system as it affects Indians...is committed to encouraging provinces to maintain their role and to filling gaps in necessary diagnostic, treatment and rehabilitative services."

The Health Transfer Program, initiated in 1989 by the federal government, has enabled the First Nations to begin the process for the control of delivery of health

services on reserve. Concerns have been expressed that the Transfer Program is a process of off-loading of responsibility by the federal government to the First Nations and to the provinces (Speck, 1989; Comeau & Santin, 1990).

The 2001 Census has indicated that 47% of Aboriginal people now live in urban areas. Ongoing jurisdictional issues continue to affect the delivery of services for First Nations people in these urban centres.

The federal government states it has primary responsibility for First Nation peoples living on reserve while the province holds to the position that all Aboriginal people are the responsibility of the federal government (Hanselmann, 2003). The application of eligibility criteria for non-insured health benefits for First Nation people off reserve creates further difficulties for First Nation peoples who have relocated. It is the perception of urban Aboriginal groups that both the federal and provincial governments are responsible for the health of Aboriginal people living off-reserve (Statistics Canada, Health Reports, 2002; Hanselmann, 2003).

2.6 First Nations Health Transfer

The historical lack of co-ordination, coupled with the persistent disparities in the health status of First Nation peoples comparable to the rest of Canadians, has established the need for a different approach to health service delivery for First Nation people. Historical events and reports highlight the need for comprehensive services, which meet the unique needs of Aboriginal communities as defined by First Nation peoples.

2.6.1 Policy Framework

The Indian Health Policy of 1979 (Appendix 6) identified the principles for future development of health services for Native people. The expectation was that, at each of the levels of community, government and health service administration, the parties involved are to play an active role in achieving the policy's goal.

"Achieving Health For All – A Framework for Health Promotion" was released in 1986 by the federal Minister of Health (Epp, 1986). The Framework identified the health challenges as a need to reduce inequities, increase prevention, and enhance coping. It established health promotion mechanisms as those of self-care, mutual aid, and healthy environments. It identified implementation strategies as those which would foster public participation, strengthen community health services, and co-ordinate healthy public policy.

Following the release of this report, on the heels of the Indian Health Policy of 1979, the Berger report of 1980, and the Penner Report of 1983; the federal government moved forward with the Health Transfer Policy in 1988. This was followed by Treasury Board approval for the Health Transfer Initiative in 1989. Health transfer would further

the principles of health promotion under the control of First Nation communities, as well as the principles as identified in the framework of the Indian Health Policy.

The Health Transfer Initiative was to establish the process for the transfer of responsibility for federal Indian health services to First Nation communities. A summary of the Transfer Initiative in 1997 indicated that:

> "The 1988 Indian Health Transfer Policy provided a framework for the assumption of control of health services by First Nations people, and set forth a developmental approach to transfer centred on the concept of self-determination in health." (Health Canada, Ten Years of Health Transfer First Nation and Inuit Control, 1999, p. 7).

The transfer was to occur within the existing legal framework, and within the existing funding base. Each community had the option of entering in to discussions with Health Canada for the purpose of assuming control of health service delivery. The federal government included a short-term and a long-term evaluation strategy for the Transfer Initiative, which would occur at three and five year intervals. A review of the findings of the Transfer Initiative Evaluation is included in section 2.6.6.

2.6.2 Community Profiles

Geographic isolation and the level of basic services provided in communities has had an effect on the degree to which First Nation communities assume control over health service management. The federal government has defined communities by four types, based on the degree of isolation and accessibility to health care:

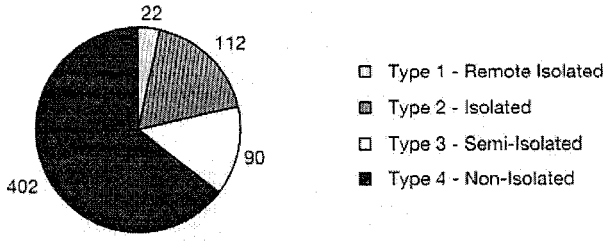
- Type 1: Remote-isolated – no scheduled flights, minimal telephone or radio services, and no road access;
- Type 2: Isolated – scheduled flights, good telephone services, and no year round road access;
- Type 3: Semi-isolated – road access greater than 90 km to physician services; and

➢ Type 4: Non-isolated – road access less than 90 km to physician services.

The provision of basic services in an isolated fly-in community would require a different level of resources than a non-isolated community within easy transport to an urban centre. The Ten Year Review of Transfer in 1999 identified 41% of communities nationally, as being under First Nation and Inuit control: 43% (170/400) of non-isolated communities, 36% (32/86) of semi-isolated communities, 38% (35/93) of isolated communities, and 35% (7/20) of remote-isolated communities.

Figure 11: Community Profiles

Number of First Nations and Inuit Communities by Degree of Isolation, 2002



Note: The data includes all First Nations and Inuit communities in the provinces, not only those reporting health information for this publication.
Source: Health Canada, First Nations Inuit Health Branch in-house statistics.

Distribution of the First Nations and Inuit Communities by Region, 2002

	Non-isolated	Semi-isolated	Isolated	Remote isolated	Total
Pacific	153	31	14	8	206
Alberta	31	19	4	4	58
Saskatchewan	62	12	8	2	84
Manitoba	27	10	24	1	62
Ontario	78	12	27	7	124
Quebec	17	6	29	0	52
Atlantic	34	0	6	0	40
	402	90	112	22	626

Source: Health Canada, A Statistical Profile on the Health of First Nations in Canada.

2.6.3 Planning Phases

Transfer of health services includes three phases following the initial consultation process: Pre-transfer Planning, Bridging, and Transfer Implementation. The Pre-transfer Planning phase is expected to be completed within twenty-four months; and activities include research, community health needs assessments, assessment of community health status, training of health committees and staff, community awareness workshops, and a community health development plan. Health management funding is provided during the pre-transfer phase and on an ongoing basis following transfer.

After a full transfer agreement is signed, First Nation communities would be expected to deliver all health services, including the mandatory programs such as communicable disease control, environmental and occupational health and safety programs, and treatment services. An evaluation of the programs under transfer was to be completed. Full funding for program delivery is implemented at this point, and the federal governments' relationship with the community is altered. The federal governments' relationship with First Nation communities changes, from one of direct service provision, to one of support and shared responsibility.

Some programs, such as communicable disease control, continue to be governed by provincial legislation. Established protocols for the management of communicable disease control and the relationship between the federal/reserve lands and provincial legislation must be clearly defined. The liability and insurance for facilities, and the health professionals providing the health services are issues for consideration.

Agreements between the province, and the framework for assuring compliance of health professionals within their respective licensing bodies, must be established to

ensure the protection of the workers as well as the public they serve (Ten Years of Transfer, 1999; Postl et al, 1988).

2.6.4 Infrastructure and Resources

Transfer was designed to occur within the existing legal framework and budgets. First Nations have expressed concerns that the funding base is inadequate to meet the health needs of a growing population, and the limits to this base do not allow filling of gaps that exist in health care services. Speck (1989) was critical of the intent of transfer, and felt that it represented efforts to:

> "legitimize cut backs in social and health services by transferring responsibility for health and health care from the state to individuals and groups within the population". (p. 208)

She described it as a transfer of responsibility without the transfer of power.

These concerns have resulted in efforts by the federal government – both First Nations and Inuit Health Branch (FNIHB) and Indian and Northern Affairs Canada (INAC) to look at how they must co-ordinate their activities. In addition to the need to identify gaps in service delivery; issues of process around health care delivery arose on a regular basis. Conflict and ambiguity necessitate some changes to the overall template for transfer planning and implementation.

Transfer has been a work in progress – over time, clauses to address confidentiality and medical records, continued responsibility of the federal government, evaluation, termination, Treaty rights, land claims and mandatory programs have been added, or revised in an effort to clarify expectations and process. Non-insured health benefits were not eligible for transfer at the outset. Recognition that the First Nation communities entering into full transfer had a need to provide services throughout the full

continuum prompted changes to this policy, and some communities or Tribal Councils have assumed management responsibility for non-insured health benefits under their transfer agreement as a pilot project.

2.6.5 Evaluation

A short-term evaluation of transfer was conducted in 1991. It reviewed the transfer process, pre-transfer planning, post-transfer administration and the impact of transfer on the involved communities. The conclusion was that the process enabled First Nations to effectively plan for transfer.

The long-term evaluation was conducted in 1995. The focus of this evaluation was to assess the success of the Transfer Initiative through an examination of the impacts and effects of transfer, identification of alternatives to transfer, and whether or not transfer had met the objectives. As reported by Health Canada (1999):

> "the objectives of transfer have been realized at the community level for communities that entered the post-transfer phase; community members had an increased awareness of health issues, and health care had become more of a priority in transferred communities; social and community development strategies were found to be in place using a variety of culturally sensitive and relevant methods of health delivery; and community health services were found to be integrated with other programs and services such as social services, mental health, home care, education and non-insured health benefits." (Health Canada, 1999, p. 23).

The evaluation did not attempt to measure any change in health status as a result of the transfer.

2.6.6 Evaluation – Key Issues of Contention

The long-term evaluation report in 1995 identified some key issues that had an affect on the transfer process (Table 4). The process that was followed had contentious areas for both Health Canada staff and the involved First Nations. The need for role

clarity for Health Canada and First Nations in the pre- and post-transfer phases was identified. Outstanding issues of jurisdiction, adequacy of funding resources and a lack of established protocols for federal/provincial relations were concerns for First Nations. The need for an established residual role for the federal government was identified. This section will elaborate on some of the findings and conclusions of the Long Term Evaluation of Transfer in 1995.

Process

The lack of clarity on the scope of the transfer initiative created difficulties for First Nations and for Health Canada staff. First Nations felt that the transfer negotiation process was often adversarial, with Medical Services Branch (MSB) staff lacking in collaboration and assistance during pre-transfer, and exhibiting rigid attitudes during the negotiations prior to full transfer. MSB staff felt that the process was locked in to rigid plans without much flexibility and felt that the term 'negotiations' gave false impressions and should not have been applied to the process. In Manitoba and nationally, First Nations said they experienced adversarial attitudes during the negotiation process. Some of the expectations for reporting and evaluation were felt to be unreasonable, as the guidelines for the reporting and evaluation criteria were not provided.

The need for established processes between the federal and provincial governments for services for First Nations was emphasized. Transferred communities identified a need to have federal-provincial protocols for mandatory service provision in the areas of public health and community nursing. Templates of formal agreements between the federal and provincial governments for these services were not available. As a result, transferred communities indicated unease when establishing temporary

agreements with provincial governments in the fields of community health nursing and public health programs. Provincial health reform affects the level of service required at community levels, and resource allocations under the transfer agreements must address this. Programs of concern for First Nations undertaking transfer are home care, home nursing and public health services, as they are specifically affected by provincial health reform.

Table 4: Health Transfer Evaluation – Key Issues of Contention

Process:
➢ adversarial relationship
➢ lack of clarity on roles
➢ rigid approach to negotiation
➢ unresolved jurisdictional issues – public health/mandatory programs
Role clarity:
➢ role of Health Canada and First Nations
➢ role of province and regional health authorities post-transfer
➢ residual role of the federal government
Outstanding issues:
➢ unresolved jurisdictional issues
➢ adequacy of funding resources
➢ need for established protocols for federal/provincial responsibility
Residual role of the federal government

Role Clarity for Federal Government and First Nations Post-Transfer

There is a lack of clarity on the ongoing role of the federal government following transfer. The role of the federal government and the First Nations in policy issues and in operational management is ambiguous. In addition, there is a need to establish partnerships with the provincial government and regional health authorities for integrated services for residents of First Nations transferred communities.

The scope of federal regional management services needs to be clarified for the benefit of First Nation communities and to ensure the parameters of the ongoing relationship with the federal government at the regional level. Jurisdictional issues between First Nations, provinces and the federal government must be resolved to allow negotiation of service agreements with local provincial agencies following transfer. Fragmentation of service as a result of jurisdiction in the areas of federal non-insured health benefits and non-insured provincial services such as diabetes education and home care were cited as problematic. Jurisdiction for public health legislation on reserve post-transfer remains an ongoing issue.

Manitoba has twenty-three isolated or semi-isolated communities that receive primary and emergency care from nurses who work in the community in an expanded role. Their scope of practice in the expanded role includes assessment, treatment and diagnosis. The nurse-based practice is supported by an itinerant physician service, where the physicians provide consultant services on site. The licensing body for nurses, the College of Nursing, does not recognize the expanded scope of practice of these nurses in Manitoba; and as a result, malpractice and liability insurance coverage is an issue for nurses and employers in these communities undergoing Transfer. First Nations and Inuit Health Branch has continued to hire the nurses on Interchange agreements with the transferred Bands to allow the community the opportunity to proceed with full transfer of health care professionals.

In Manitoba, the evaluation revealed the First Nations perspective that the federal governments' reluctance in recognising health as a Treaty right had caused delays in the transfer process. The 1964 Canada/Manitoba Agreement on Health Services Delivery

affected the transfer discussion process as First Nations were required to enter negotiations with both federal and provincial representatives. The evaluators noted that:

> "The unresolved jurisdictional problems between the federal and provincial governments has caused a deadlock in transferring health services in some communities." (Long Term Evaluation of Transfer, 1995, p. 39).

Efforts in dealing with provincial governments when First Nations had previously only dealt with the federal government were barriers to transfer, in that established roles, networks, processes and protocols between the federal and provincial governments were not in place (Long Term Evaluation, 1995).

'Residual Role' of the Federal Government

One outstanding issue is that of the residual role of the federal government in transferred communities. A working group was struck in 1998 to review the need for a federal residual role in First Nation communities post-transfer. Key principles for discussion on the residual role included the role of the federal Minister of Health, the sustainability of the transfer process, and the establishment of linkages with other health and social jurisdictions (Strategic Priorities Project, 1998).

The role of the federal minister must include the ongoing responsibility for the health and protection of First Nations and Inuit peoples, as for all Canadians. In order to address the issues of advocacy and the provision of mandatory programs within existing provincial legislation, the federal government will need to take a lead role in establishing the protocols necessary for routine operations in these areas.

2.6.7 Alternatives to Health Transfer

In 1994, Treasury Board approved the Integrated Community-Based Health Services Approach. This was an alternative option to transfer for communities for the achievement of limited control over health services. In 1995, the federal government announced the Inherent Right to Self-Government Policy, which recognizes that First Nations have the constitutional right to define their own forms of government to suit their own particular historical, cultural, political and economic circumstances (Ten Years of Transfer, 1999). This allowed communities to further increase the level of control of health services.

The present system allows for a variety of ways that health services are delivered and administered:

- direct First Nations and Inuit Health Branch delivery of services;
- contribution agreements and stacked agreements (agreements for multiple programs);
- integrated community-based services; or
- health services transfer.

In all levels of transfer agreements, it is necessary for First Nations to dialogue with provincial agencies to effectively delivery co-ordinated health programs.

The need for resolution of jurisdictional issues continues. Establishing a process for dialogue to begin addressing these issues at a provincial and territorial level would eliminate many of the difficulties that First Nation communities face when attempting to establish service agreements post-transfer.

2.7 Public Health Services

A key area identified as problematic was that of legislation for public health services for First Nation communities. This issue arises through the routine delivery of mandatory programs on reserve, and is often cause for contention between service providers in the province as a result of jurisdictional ambiguity. Jurisdictional responsibility for public health services requires specific consideration.

The jurisdictional responsibility for application of the Public Health Act on reserve land in Manitoba has been an ongoing question, and has been the subject of 'legal opinions' by both levels of government over time. Both federal and provincial governments have some jurisdiction in public health; and provincial legislation applies on reserve land if it does not impinge on the power of the federal government under the Indian Act. Clarity on the roles of public health practitioners under this legislation in the current health care system, and how they would apply post-transfer, has not been achieved.

The federal government has systems in place to comply with the requirements of communicable disease control in the province. The management of these programs is the responsibility of First Nations and Inuit Health Branch (FNIHB), with communicable disease coordinators reporting to a Regional Programs Medical Officer (RPMO). The RPMO has the role of director of public health practice on reserve. S/he has not been appointed by the provincial Minister of Health as a Medical Officer of Health, so does not have the authority to uphold legislation under the Public Health Act.

With health transfer, this role must be defined and the differences between the RPMO and the legislated functions of the provincially appointed regional medical officer

clarified for the First Nations. The federal document entitled 'Medical Officer and Transfer' (1997) does not establish a process for ensuring compliance with provincial legislation in public health. The federal government has issued documents on the residual role of Health Canada following transfer. There is a need for clarity on pre-transfer roles in order to effect a smooth transition (Transfer Handbook, 1989; Medical Officer of Health post-transfer, 1997). It is necessary to establish policies and protocols for routine operational activity, legislated and otherwise, for public health practice within provincial jurisdiction on federal/First Nations lands.

Since there are no federal regulations for health care, it would appear that, unless First Nation communities establish alternative by-laws; the provincial Public Health Act would be applicable on reserve. Provinces cannot refuse services to First Nations that are available to all other residents, however, the process for application of the Public Health Act on reserve remains unclear.

2.8 Summary of Literature Review

The literature review suggests that health care for First Nation peoples has evolved into an established pattern where-in neither the federal nor the provincial governments have accepted the mandate and taken responsibility. There is a need for comprehensive health programming and co-ordinated service delivery to meet the needs of the First Nation peoples within the provincial and federal systems.

Many consultative processes over the years have clearly indicated the need to resolve jurisdictional issues. At the national level, the federal government has not taken the primary initiative to meet with provincial and First Nation governments and begin the process of reconciling jurisdictional issues in a meaningful way.

Jurisdiction for health for First Nation peoples does include concurrent responsibilities through both the provincial and federal governments. First Nation peoples are eligible for all insured services. The issue requiring clarification is that of provision of service on reserve. Despite the persistent nature of the health issues; over the last century, a formal process for addressing health and social disparities has not been established.

The initial hope and commitment by First Nations in entering into the Transfer process has been challenged by fiscal restraints and a lack of committed resources at the Tribal Council or community level. If unresolved jurisdictional issues have not been addressed, the ambiguity around fiscal responsibility and levels of service delivery could affect a transfer process. Clear lines of authority through documented roles and responsibilities with established communication and referral processes are important basic criteria for effective collaboration in service delivery.

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

3.1 Methods

The purpose of this study was to gain information as to potential ways that unresolved jurisdictional issues may have affected the health status and health care of First Nation peoples in Manitoba. The policy directives governing First Nation peoples health care delivery were reviewed and supplemented by key informant interviews.

Consultation with First Nations was initiated through the Health Information and Research Committee (HIRC) of the Assembly of Manitoba Chiefs (AMC). The HIRC consists of representatives from the seven Tribal Councils in Manitoba, representatives from the northern and southern Independent communities, and representatives from the Assembly of Manitoba Chiefs. The relevance of the study for First Nations was discussed and a draft proposal for the study was shared with the Committee. Approval and support for the study was granted by the HIRC. The HIRC identified Doreen Sanderson, Policy Analyst with the AMC, as a primary contact and advisor for the study. The results of the study were presented to HIRC representatives for review and feedback.

Policy documents relevant to health care delivery for First Nation peoples were identified and reviewed. Key informants were asked to share any documents that they felt may be relevant to the study. All documents referenced in this text were available in the public domain or were shared with the researcher by officials at the relevant federal, provincial and First Nation government levels.

Key informant interviews were a rich source of data. The case studies described by the informants, and the interview narratives document the perspectives and

perceptions of participants through their experiences while actively involved in the field of First Nation health services delivery, either presently, or in the past.

Personal reflection from the researchers' perspective added a further dimension for verification of results. This component of the study, in conjunction with the policy review and key informant interviews, corroborated the data through the process of triangulation.

3.2 Ethnography

The primary research method involved the development of a critical ethnographic study. Ethnography permits an in-depth description of behaviour over time of specific groups of people and their actions. To explore the relevant jurisdictional issues which have had an affect on health care delivery for First Nation peoples, an ethnographic study of the policy directives governing First Nation peoples health care delivery was chosen.

A 'critical ethnography' is defined by Creswell (1997) as one in which the researcher has a political purpose to challenge policy, where the research begins with the assumption that the cultural members of the group experience unnecessary repression to some extent.

The purpose of this policy review was to identify and explore the perceptions of individuals of the implications of policy statements or directives for First Nation peoples health care in terms of jurisdictional issues. Jurisdictional limitations have often been cited as the reason, or rationale, for not providing a specific service to First Nation peoples. Jurisdictional limitations or ambiguity has created difficulties for individuals in accessing service due to misconceptions or misunderstandings about the service availability for First Nation peoples.

The structure of health service delivery was documented through a review of relevant documents. Key informant interviews with government officials and decision-makers, policy makers in health care, health care administrators, and health care providers explored the perceptions of service delivery for First Nation peoples. Interviews focused on the issues of jurisdiction on those services, if any. All prospective key informants were involved in government at the federal, provincial or First Nation levels, were policy or decision makers in health care or health service delivery, and/or

were health care providers for First Nation peoples. Key informant interviews were conducted using a semi-structured format. Interviews were centered around case studies illustrating jurisdictional issues and their effects on policy.

3.3 Key Informant Interviews

Early discussions with the Health Information and Research Committee (HIRC) of the Assembly of Manitoba Chiefs resulted in support for and approval of the study and its topic of jurisdiction in First Nation Health. The potential benefits of the study were discussed. Some suggestions for the process and focus for discussion were offered by members of the HIRC.

Key informants are defined as individuals with important knowledge in specific areas. The study involved reviewing and exploring the effects of unresolved jurisdictional issues on health care delivery based on the perceptions of individuals involved in various levels in the health care planning and/or development or delivery of services for First Nation peoples.

The key informants were selected based on their individual experience with the First Nations health system, or their present role in the system of health care delivery. The variation in the level of basic services in communities and the level of health transfer is a result of geographic differences and degree of isolation. These factors influenced the key informant sampling selection. The advisor assigned by the Assembly of Manitoba Chiefs identified several individuals as key informants in health care administration and delivery within First Nation communities.

Letters of invitation explaining the study and consent forms were forwarded to all individual identified potential key informants. Follow up telephone contact was made with all potential key informants to identify those individuals who were interested and willing to participate in the study. Interviews were scheduled with each key informant at the time and place of their choice. Consent was obtained, and each was assured that their

comments would be reported in a general way and not attributed to individuals (Appendix 8).

All key informants agreed to participate in taped interviews. Key informants were interviewed in person or by telephone, with tape recording. All interviews were semi-structured, and focused on individual experiences in health care delivery where jurisdiction played a role in the resolution of an issue or situation (Appendix 9).

Table five shows the distribution of key informants in terms of their role and involvement at the federal, provincial or First Nations level.

Table 5: Key Informants (n = 20)

Federal Government	Policy/Decision Makers
	Health Care Administrators
	Health Care Workers
Provincial Government	Policy/Decision Makers
	Health Care Administrators
	Health Care Workers
First Nations Governments	Policy/Decision Makers
	Health Care Administrators
	Health Care Workers

Policy and Decision Makers includes Regional/provincial Administrators, decision and policy makers
Health Care Administrators includes Directors of Programs or Program Development
Health Care Workers includes physicians, nurses and community health service providers

3.4 Interview Process

Prior to beginning the actual interviewing of key informants, pilot interviews were held with key informants. The questions were re-focussed and refined, and structured to allow informants to share their own personal perceptions and views.

All key informants were interviewed in the location of their choice. Generally, this was in their work place at the end of the day, or in a neutral location – quiet restaurant, or in their home. Some interviews were pre-arranged and conducted by speaker telephone on tape.

The letter forwarded to all key informants was reviewed and the study explained. The individuals all signed the consent form and agreed to taped interviews prior to beginning the interview. Open-ended, semi-structured interviews were conducted, and generally lasted for forty-five minutes to one hour in duration.

Information on the roles and responsibilities of the key informants in the Aboriginal health field was kept in a journal. The roles and responsibilities were confirmed in the interview. This information was described in a very general way in the analysis narrative of the study as a means of establishing the validity of the data. The identity of the individual was kept confidential and the tapes and transcripts kept separate from the consent form. The tapes of the interviews, and the journal will be destroyed at the end of the project.

3.5 Interview Analysis

The interviews were transcribed verbatim in a Question & Answer format, using Microsoft Word software. All interviews, including the pilot interviews were analyzed together.

The material gathered was analyzed using constant comparison framework where key themes were identified and coded. The data was interpreted and coded based on the themes identified. Informant responses are presented in narrative quotations from the key informant interviews. The case studies described by the key informants reflected the effects that jurisdiction can have on the service delivery for First Nation peoples.

Results of the analysis were discussed with some key informants to assure appropriate interpretation. Copies of the report were distributed to some participants for discussion of the results. A final report will be presented to the HIRC, in addition to a formal presentation of results.

3.6 Data Trustworthiness

Reliability and validity are the measures utilized to assess the trustworthiness of data generated by quantitative studies. They are important in assessing the generalizability and reproducibility of the data and final conclusions. External validity assesses the degree to which a study can be generalized to other circumstances and subjects (Creswell, 1994). In many qualitative studies, it is the uniqueness of a problem or behaviour observed with a specific context that is the focus. Less emphasis may be placed on generalizability. Qualitative researchers establish reliability through the detailed documentation of the process of data collection where they describe their own interaction and impact on data collection and interpretation (Yin, 1989, cited in Creswell, 1994). In this way, other researchers could follow the same process and arrive at similar results.

Internal validity addresses whether the study is using accurate information and is reality based. In qualitative research, the methods would be more appropriately reflective of internal validity since real people's perceptions or experiences are identified. Internal validity, or credibility of a study, can be established through triangulation.

Triangulation is a concept utilized in qualitative and quantitative research as a methodology to limit bias in data collection and analysis. Data is collected in a combination of ways to ensure that data is reflective of all perspectives of the issue (Creswell, 1994). It is a form of corroboration of the data. By accessing multiple sources, methods and theories to document the same behaviour or phenomenon, potential errors will be minimized (Creswell, 1997). Accessing policy documents, interviewing key informants and personal reflection by the researcher will establish the basis for verification of results.

Verification of results occurs in a study during the data collection and narrative writing phases of development. The data collection includes the observation, recording and analyzing of the data. During the interpretation of the narrative, the writer must be aware of how personal values and experiences influence our work. The need for accurate information through documented research and participants perspectives will minimize the writers bias in determining the ability of the study to challenge any injustices. Subjectivity is always an issue in the interpretation of data, and while it is helpful in qualitative research, we must also be aware of the potential for bias.

3.7 Ethical Considerations

The principles of community-based research emphasize the need for participation by the community involved. The ethics statement in the recommendations of the Royal Commission on Aboriginal Peoples (1996) stated:

> "In studies that are carried out in the general community...consultation on planning, executive and evaluation of results shall be sought through appropriate Aboriginal bodies." (p. 326)

Consultation for this study began with an initial discussion with a Policy Analyst on Health for the AMC. She recommended the proposal be presented to the HIRC for further discussion. The draft proposal was presented to the HIRC, and discussion occurred on the potential benefits for First Nation communities. Subsequently, support for the proposal and written approval for the study was committed by the HIRC in October of 2002. An advisor was assigned to work with the author on the project. Updates to the HIRC were conducted, and recommendations for revisions to the process were provided, and incorporated in to the design.

This proposal was granted approval by the University of Manitoba – Faculty of Medicine – Health Research Ethics Board in January of 2003.

All research involving human subject participants must have informed consent. All participants were contacted initially by letter advising them of the study and its intent, and requesting their voluntary participation in the study. The potential participants were contacted by telephone as a follow up to identify those who were interested and willing to participate in the study. All individual volunteer participants who agreed to participate were assured of confidentiality. Written consent was obtained from all participants prior to beginning the interview process. The consent forms were stored separately from the

tapes. The tapes, transcriptions and consent forms will be destroyed upon completion of this study.

3.8 Investigator's Perspective

In this qualitative study, the researcher is a research instrument, and the author's background and experience, as well as the author's connection to the Aboriginal and professional community, is important.

As an Aboriginal (Metis) physician, with immediate and extended family members with First Nation (Treaty) status, either through historical treaty or through re-instatement under Bill C-31, I have a personal connection to the community.

I grew up in a semi-isolated community in the northern Interlake of Manitoba, and attended a residential boarding school for my high school education. Throughout my life, and into my early adult years, we lived in communities with little or no physician coverage, and little or no on-site community health nursing coverage. Transportation to the nearest town for consultation with a physician was difficult, and costly, to arrange. As a result, this was a rare occurrence.

My professional career includes experience in family practice in First Nation fly-in nursing station communities and federal hospitals on reserve. During that time, I worked under contract to the J. A. Hildes Northern Medical Unit of the University of Manitoba, which had contractual arrangements with the federal and provincial governments to provide health services to First Nations. My urban family practice experience consisted of working in family practice in a core area urban community clinic setting, where my primary client base was Aboriginal, and private family practice in a suburban setting.

Public health experience was gained as a provincial regional medical officer of health in the Nor-Man Region of Manitoba, and presently at the Winnipeg Regional

Health Authority. The delivery of Public Health programs as a Regional Programs Medical Officer with Health Canada provided a federal perspective of public health responsibilities in First Nation communities.

Health services administration and management experience was gained at the University of Manitoba and Health Canada. As the Associate Director of the Northern Medical Unit, I gained experience in program planning and contract negotiation for service provision in First Nation communities. As a health care administrator for Health Canada's First Nations and Inuit Health Branch, I had the opportunity to organize and coordinate services in primary care, dental programs, mental health services, public health and community based programs, including the home care program development.

As a physician, I have had many personal experiences co-ordinating service for my Aboriginal patients. These experiences were occasionally difficult and time consuming because of unclear guidelines, and difficulties applying guidelines in determining service entitlement. Health care providers often must be patient, but persistent, when arranging or co-ordinating services for First Nation patients. It has been my experience that frequently, the range of standard practice of what service providers within the system will, or will not do, may be the result of their own experience or perceptions of what they can, or cannot do, for First Nation patients. Frequently, the actual policies are elusive, but providers 'have been told' that they can or cannot provide a range of services or benefits.

Shared dialogue with First Nation patients and health care administrators allowed the opportunity to advocate on their behalf within the systems of government services and health care provision. It has been my experience that First Nation peoples face

personal frustration, and intimidation by service providers who are themselves frustrated with the system. Service providers generally have either a lack of awareness of 'the system', or their own subjective interpretation of eligible benefits and services for First Nation peoples. The onerous process that health care professionals must follow to ensure patient access to these benefits sometimes requires more effort and time than these individuals may have available or are willing to commit to the task.

As a previous northern clinician in remote First Nation communities, and as a program administrator across jurisdictions, I acknowledge that I have developed awareness, and formed opinions, of the experiences faced by First Nation peoples in the health care system. Some of the key informants are individuals with whom I have worked closely, either as colleagues within the same organization, colleagues within the same community, or as collaborators in program development or implementation at both a policy and service delivery level.

In doing this study, some informants, on occasion, would expect that I had an understanding of their perceptions – "Well, I guess you know what that's like", or "You know what I mean, you worked there". Frequently, it was expected that I would recall events, or situations and outcomes that were general knowledge in the Aboriginal community, and that I would then infer the meaning of the response to a query in the interview. There may have been situations in the interview process where my previous relationship with individuals influenced the response given.

I have had personal experiences with my family in the First Nation health care system, both on and off reserve. As a result, I have insights into the expectations of

family on the health care system, but also, insights into how both positive and negative experiences in health care can affect the family dynamics.

I have had the opportunity to experience professional successes and dilemmas when providing comprehensive health care for First Nation peoples. As a direct provider of health services, I have had real experiences in the complexities and difficulties in arranging services. As a program developer, I have experienced the need to balance effective and efficient services that were culturally appropriate and relevant, and also cost-effective and sustainable.

Although some of these previous contacts and experiences may have disadvantaged some components of this process, there were many more advantages. Through my experiences as a service provider in the system, I had established some credibility as a professional and as an Aboriginal person, within the system. A previous working relationship with individuals who all share some component of a common vision for health service delivery for First Nation peoples was one distinct advantage in the process.

3.9 Biases and Limitations

3.9.1 Biases

The researcher is an Aboriginal (Metis) physician who has had many personal experiences, where-in the co-ordination of service for patients who are First Nations was difficult and time consuming as a result of difficulty in interpreting guidelines for service. Many providers or decision-makers have their own interpretation of what services or benefits are provided for First Nation peoples.

The researcher recognizes personal biases as a former northern clinician, and program administrator in several jurisdictions. The researchers' life and career experiences will have an affect on the interpretation of the data collected.

As a provider of health services, and a program developer of services, the researcher will also have insights into the difficulties in arranging these services, and how the perceptions of jurisdictional responsibility impact those decisions made by providers.

3.9.2 Limitations

Interpreting this data is subject to the limitations of most qualitative research studies. The situations described by individuals are presented in a consistent way throughout the course of this study. Frequently, similar case studies were presented from different perspectives, and this strengthened and contextualized the value of the data.

In this situation, the researcher has had extensive contact with key informant individuals in the field on a professional level. As part of this system, participants may have had a perception of the perspective they felt the researcher would hold, and may have phrased their responses accordingly. Opinions may have been expressed based on their own personal situation in a workplace. Although individuals were asked to provide

responses from their own personal perspectives, and not as an employee of an organization, it is difficult to remove oneself from that role.

The study involved participants from a variety of roles within the health care system, and from different geographic locations, with differences in health care delivery process. The time available for data collection and analysis limited the number of individuals who could be consulted.

CHAPTER 4

FINDINGS AND DISCUSSION

This chapter will present narrative data gathered in key informant interviews and interpreted in the context of the analysis of official policy documents and relevant literature.

4.1 JURISDICTIONAL AMBIGUITY IN FIRST NATIONS HEALTH CARE

Ambiguity is defined in Oxford as "a double meaning which is either deliberate or caused by inexactness of expression, or an expression able to be interpreted in more than one way". (p. 34)

Much of the difficulty in addressing the health needs, in a comprehensive way, for First Nation peoples, is a result of historical jurisdictional ambiguity. The rights of the Aboriginal peoples defined within the Constitution Acts (Giokas & Groves, 2002) are still ambiguous and contested. The historical relationship between First Nations and the federal government is characterized by a lack of trust, by confrontation, and by a lack of recognition of First Nations as equal partners. A key informant in the First Nations community indicated that:

> *"..when you're looking at jurisdictional issues and how the government has driven the process, there's no ownership by First Nations...I see myself as a tool, I see myself as an inconvenience and I see myself as an obstacle to these individuals..."*

The Canadian public has assumed many impressions of First Nation peoples. One impression is that of a cultural group who are seen as being unreasonable in their demands and 'expecting something for nothing' from the Canadian government and subsequently, the Canadian public. First Nation individuals who perceive this negative attitude suffer resultant negative effects to their self-esteem and overall well-being. Weaver (1985) summarizes Aboriginal rights as:

> "a complex, emotionally charged, multivalent symbol that represents native demands for recognition as a unique cultural group; that is, as Aboriginal people." (p. 141)

Confrontations with the federal government have resulted in minimal forward movement for the establishment of First Nations rights; this despite the optimistic views

in the 1970's and 80's that government was finally moving toward the recognition of the rights of the First People of this country. First Nation leaders continue to hold firm to the expectation that federal leaders will honor the treaties between the First Nations and the Crown. In 1983, at a treaty conference, Chief John Snow (Snow, The Quest for Justice, 1985) stated:

> "The federal government has repeatedly reaffirmed, through the office of the prime minister and through the minister of Indian Affairs, that our treaty rights will be respected. But the government has subordinated the treaty agreements to other legislation. In effect, the federal government has arbitrarily changed the rules when it didn't like them....Our treaties present a dilemma to the federal government because they confirm that we are not just another minority group in Canada, but that we are the original peoples with special rights and special status." (p. 42)

The attitudes of Canadians towards First Nation and other Aboriginal peoples have generally been less than respectful, particularly when there is a need to collaborate on potential mutual interests. Miller (1989) states that:

> "George Manuel (AFN) has argued that Indians will achieve political victories that do not entail political losses for the rest of the Canadian community....The problem for the electorate at large is that it cannot perceive an Indian victory that does not entail a corresponding loss for non-natives..." (p. 284)

As a result of the ambiguous approach to resolution of First Nation issues historically, the federal government is not unable to make definitive decisions on the rights of First Nation peoples without incurring resistance from the general electorate of Canada.

The health status of a people is dependant on many social determinants of health, including biological and cultural influences and access to health services. The health problems experienced by First Nation peoples exceed those of non-Aboriginal people, and the per capita costs for health services for First Nation peoples are greater than for

non-Aboriginal people generally. Jurisdictional responsibility for health programming has been vaguely defined in most provinces, and almost always results in the impression that First Nation peoples are imposing their needs on government and health programs. Governments have long resisted the substantial costs of providing sustainable and full funding of social programs that would make a difference over time in health status. Health promotion and prevention services, which are recognized to make a difference in health status, have been under-funded as governments struggle to cope with the significant financial costs associated with the need to address health care crises. As a key informant, a First Nations policy-maker indicates that:

> *"...the federal government has totally denied quality health to First Nations just by the mere fact of allowing so many departmental involvements, so many different departments, making their policies as vague as possible, and making it almost impossible to access treatment or care. The Department of Indian Affairs major responsibility is on the social side and Medical Services is responsible for another area, and anything that doesn't fit the two molds is passed on to the province..."*

The need for collaboration across multiple departments to ensure effective health and social services planning has both complicated and fragmented service delivery for First Nation peoples.

4.1.1 Colonialism and Historical Perceptions of Aboriginal Peoples

The Oxford dictionary defines colonialism as "a policy of acquiring or maintaining colonies; or, this policy regarded as the esp. economic exploitation of weak or backward peoples by a larger power" (pp. 22-23). The concept of colonialism, and the subsequent effects on the indigenous peoples of this country; brings forth a comprehensive visual image of the present state of being for First Nation peoples. In

1995, a Manitoba Health document (Postl, 1995), included an Aboriginal Chapter which indicated that:

> "To understand why there is high mortality and morbidity rates is to seek causes, most of which are historical. Political, social and economic censure was a process generated by the colonialism of First Nations which resulted in subjugation, a clear manifestation of hierarchical imported authority." (p. 91)

The ideology of colonialism and its effects on policy decisions for First Nations is poorly understood by the general public, by health care providers, and often by Aboriginal and First Nation peoples as well.

Berry and Wells (1994) reviewed attitudes toward Aboriginal peoples, and identified two key issues that arise in the acculturation process when societies interact. One is whether or not one's own culture is of value. The other is whether or not relationships with the larger society are of value.

Acculturation is achieved through four separate processes. Assimilation involves the casting out of one's cultural identity and being absorbed into the larger society. Integration allows maintenance of cultural integrity while moving into the larger society. Separation of a group can occur if the intent is to maintain a traditional way of life outside the larger society, while segregation occurs when larger society imposes that separation. Marginalization is characterized by feelings of alienation, and loss of identity as the group loses its cultural identity and traditions, but also loses contact with the larger society (Berry and Wells, 1994).

As Europeans made contact with Aboriginal peoples in Canada, the relationship shifted and evolved over time. The initial relationship was one that was mutually beneficial, did not threaten the cultural integrity of either group, and was based on the

equitable roles of commercial trading partners. This evolved into one of military alliance as the French and English struggled for control of Canada, with the allegiance of Aboriginal groups. Relationships post-war became combative. Aboriginal peoples maintained their stance as allies to the British, who now saw the Aboriginal peoples as their subjects.

Assimilation Policies

As Aboriginal peoples were no longer necessary to the survival and well-being of the now dominant society in Canada, they were treated as an impediment, or obstacle to the ambitions and intentions of the British. The coercion of Aboriginal peoples that followed resulted in a dependence on the state due to the restrictive policies imposed on the Aboriginal peoples by the federal government (Miller, 1989).

Assimilation policies of the 1800's eventually evolved into the establishment of the Indian Act, which included many of the provisions of earlier legislation. Francis (1992) comments that:

> "Canadians did not expect Indians to adapt to the modern world. Their only hope was to assimilate, to become White, to cease to be Indians...Indians were considered strangers to progress". (p. 59)

Indian people wanted education for their children and agreed to collaborate with government on that initiative. However, separate education systems were established, and Indian people were settled on tracts of land separate from their Euro-Canadian neighbours.

> "The stated aim of the policy was to assimilate Indians to the mainstream of Canadian society; but the means chosen to implement this policy was segregation" (Francis, 1992, p. 216).

Francis notes that the "privileges" that Native people received resulted in resentment by the settlers, and that Native people were viewed as "different and inferior". (p. 216)

Sir Francis Bond Head was a lieutenant governor in Upper Canada who initiated a policy of assimilation in 1836 that was eventually opposed by humanitarian groups in British North America and the United Kingdom. On the assumption that 'the Indians were dwindling in numbers and were destined to die out completely' (Miller, 1989, p. 102), Bond Head took land surrendered by Indian groups and relocated them to the Manitoulin Islands 'to live out their remaining days' (Miller, 1989, p. 104)

Table 6: Assimilation Policies

1830's	Sir Francis Bond Head Policy	Land surrender with relocation to Manitoulin Islands
1842	Bagot Commission	
1850	Lower Canada Act	Protected land base and defined 'Indian'
1857	Gradual Civilization Act	
1869	Gradual Enfranchisement Act	
1876	Indian Act	
1969	White Paper	
2002	First Nation Governance Act	

The Bagot Commission of the 1840's was struck as an inquiry to review the "assimilationist education programs". (Miller, 1989, p. 104) It reaffirmed the land rights, and the right to compensation, of the Indian people. They also recommended changes to the economic development, educational strategies and management of financial responsibilities of the federal government to the Indian people. The traditional land use would be eliminated, and there would be a reduction of the federal government's

obligations. It was felt that the parental influence after school threatened the assimilation of Indian children; and Bagot recommended the establishment of residential schools which would teach the children how to farm or to learn a trade, and would minimize the influence of family and community.

The Lower Canada Act of 1850 (officially entitled 'An Act for the better protection of the Lands and Property of Indians in Lower Canada'), was initially drafted to protect the land base while the British continued negotiations with the Indian people. This was the first Act that defined who was an Indian. The 'Act for the Gradual Civilization of the Indian Tribes in the Canadas' (Gradual Civilization Act) of 1857 built on the Bagot Commission recommendations and those of the missionaries. This Act defined how the Indian people could work toward the shedding of their Indian status, become enfranchised, and gain access to land on an individual basis. As Miller (1989) remarks:

> "The legislature now was saying that it would define who was an Indian as a preliminary to making it possible for the Indian to cease being Indian.". (p. 113)

This was followed by the British North America (Constitution) Act of 1867, which assigned the jurisdiction for "Indians and lands reserved for Indians" to the federal government.

In 1869, the Gradual Enfranchisement Act was designed. This Act was more coercive in that it restricted the ability of the Indian people to maintain or establish self-government, and built further on the assimilation policies of the Gradual Civilization Act of 1857. The traditional chiefs had blocked national efforts at assimilation, and the Enfranchisement Act allowed the federal government a mechanism to manage these

leaders. They could be disempowered for 'dishonesty, intemperance or immorality' and replaced with elected officials (Miller, 1989, p. 114). There was continued resistance to the enforcement of assimilation strategies by the Indian people.

The Indian Act evolved from earlier legislation and policies directed at Indian people in Canada, and included much of the content of these earlier efforts. Following the enactment of the Indian Act in 1876, amendments occurred at intervals when the federal government sought to further control the assimilation of the Indian population. Many directives focused on removing cultural influences. Some amendments included banning of traditional ceremonies such as the Potlatch and the Sun Dance, the inability to appeal government decisions on self-governance, and the establishment of the pass system that forced Indian people to seek written authorization from the Indian Agent prior to leaving the reserve. The pass system was one means of discouraging and preventing parents from visiting their children in boarding schools. Generally, these efforts were not very effective as Indian people ignored them and enforcement was difficult. Other amendments were under the guise of being protective, and included the banning of alcohol, barring non-residents of a band from the reserve after dark, and making it impossible for Indians to sell or mortgage land (Miller, 1989; Moss, September 24, 1990; Moss, September 17, 1990). The amendments to control governance created more visible resistance and the struggle for self-government is ongoing. Miller (1989) states that:

> "Whether one looks at Upper Canada in the 1830s and 1840s, the prairies in the 1880s and 1890s, or the north in the twentieth century, the record is the same. Native groups recognized the inevitability of change and sought only to control it so that it would not prove destructive to their identity and social cohesion". (p. 277)

Amendments to the Indian Act in 1985 and 1988 were seen as interim efforts to improve the Indian Act for the benefit of First Nations. The 1985 amendments 'removed the sexually discriminatory provisions relating to Indian status and band membership,' (Moss, 1990, p. 9); and the 1988 amendments 'intended to clarify the legal status of conditionally surrendered reserve lands and thereby facilitate the power of Indian Act bands to develop their lands through leases to non-Indian persons.' (Moss, 1990, p. 10).

The White Paper of 1969 formally proposed, yet again, the federal government's intent to continue with assimilation of the First Nation and Aboriginal peoples of Canada. Meaningless consultation with First Nations resulted in all proposals put forward by First Nations being ignored by the federal government. Miller (1989) summarizes the proceedings as:

> "The White Paper adopted government solutions and ignored Indian proposals. Indians had said that they wanted economic and social recovery without losing their identity; the white paper proposed the extinction of their separate status as a step towards dealing with problems that Ottawa said were the consequence of a different status.
>
> Indians had made it clear that they intended to hold the federal government to the commitments it had made in treaties, obligations that were embodied – sometimes perversely – in the Indian Act. The White Paper proposed to absolve the federal government of its commitments by revoking Indian status, eliminating the Department of Indian Affairs, and transferring responsibility for Indian matters mainly to the provincial governments.
>
> Indians had been pressing for two decades for a claims commission that would respond to their argument that Aboriginal title justified extensive compensation for the loss of lands and resources; the proposed policy airily dismissed the concept of Aboriginal rights and explicitly rejected the establishment of an Indian claims commission.
>
> And all of this occurred after a year of supposed consultation; all this was done in the name of equality and justice." (Miller, 1989, p. 228).

As with all previous legislation and policy development, First Nations were not actively involved in the process. Again, the First Nation governments demonstrated their resistance to these efforts.

The most recent effort of the federal government to reform the Indian Act is in the form of Bill C-7, the First Nations Governance Act (FNGA). The focus of the FNGA is on governance and does not specifically deal with health or social services programming, however, it illustrates the historical approach to relations between the First Nations and the federal government. A recent critique of FNGA was submitted by Pat Martin, the NDP Aboriginal Affairs critic, MP for Winnipeg Centre in response to a previous editorial on Native reform:

> "First Nations from coast to coast have told the Standing Committee (on Aboriginal Affairs) that the FNGA is a giant step backwards. It would be the height of the colonial-style arrogance to proceed with any of these changes without their participation and consent." (The National Post, May 15, 2003, p. A15)

The federal government must work with First Nations to establish a process that acknowledges their right to be an integral component of any federal process affecting the rights and the governance of First Nations and ultimately the First Nations right to self-government.

Policy Development for First Nations

The manner in which First Nation peoples are served by health and social programs is dictated by the societal understanding that individuals have of Aboriginal peoples, and by the policies that define the program or benefit which is sought. Weaver (1985) states that:

> "Indian policy in Canada is made by individuals who hold strong feelings about whether or not native groups should be treated differently from

> other Canadians. One of the most pervasive forces underlying the federal government's resistance to Aboriginal rights demands is its steadfast commitment to liberal-democratic ideology...Personalities are a key factor in the development of policies" (pp. 141 – 142).

Weaver (1985) also notes that many of the positive policy changes of the 1960s and 1970s occurred as a result of initiatives by:

> "sympathetic officials in various federal departments and agencies' who 'function as action-oriented brokers between the government and native groups'". (p. 142)

A key informant who provides health services for Aboriginal people noted that:

> "Just a general kind of thing about Aboriginal health is that I recognize more and more that colonization and the impact of how the Canadian government and its policies has affected indigenous people, Aboriginal people. I see it as a thing that's probably not well recognized in the medical world and it's a necessary thing to know...I think a lot of the issues that we have with Aboriginal people about jurisdictional issues between whether the province is responsible for one part or the feds, to me is an extension and reflection of the control the system has over Aboriginal people, and their lack of understanding about how that impacts health."

To adequately address the health determinants that will begin to effect an improvement in health status for First Nation peoples, policy and program development must include the active participation of First Nation peoples. The lasting effects of colonialism on many First Nation communities is exemplified in *'Night Spirits'* – the history, as told by Ila Bussidor, of the affects on her people from the decisions made by the federal government on behalf of that Dene community. The social upheaval for the Sayisi Dene following a federal government decision to relocate the community of Duck Lake to Churchill is tragic, and unfortunately is one that is told time and again, with the name of the community and band the only variable that changes. The story begins with a summary of some of the events, and some of the outcomes:

> "My parents belonged to a traditional generation of the Sayisi Dene...From my grandparents they had learned well the skills of living off the land, in the same way that hundreds of generations had done before them.
>
> That gift of survival, that gift of traditional skills passed from generation to generation, would stop suddenly. It was a gift that would never be given to me and my brothers and sisters, because in 1956, the Government of Canada relocated my people from our homeland. We were left on the fringes of a frontier town, Churchill, Manitoba. For us, that is when the nightmare began.
>
> We were nomadic of tradition and of necessity.....We attempted to make a stationary life at Duck Lake, where a Hudson's Bay Company post was located...It was to have been, and should have been, a gradual adaptation to an inevitable way of living. The adaptation to stationary living needed time and patience to work.
>
> Instead, in 1956, we were airlifted off the land and left on the banks of the Churchill River. For the Sayisi Dene, this arbitrary government decision brought culture shock, disorientation and confusion. For my people, it was the beginning of two decades of destruction and suffering. During our time at Churchill, nearly a third of the Sayisi Dene perished – many from alcohol abuse and violence. For my people, the impact of the relocation had the same effect as genocide.
>
> I was born during that time, when the Sayisi Dene were stripped of everything they stood for as a people...We lived in a slum in total darkness. As a child, I learned what it felt like to be inferior to another race, to be less than the next person because I was Dene." (Bussidor and Bilgen-Reinart, 1997, pp. 3-4)

The Sayisi Dene began to leave Churchill in 1973 to build a new community at Tadoule Lake.

The preferred options for First Nation peoples in interacting with larger society in Canada have focussed on the process of integration, or alternately, separation. In contrast, historical government policies and legislation have made efforts to assimilate or segregate First Nation peoples. This often has resulted in the marginalization of First Nation groups.

Present day situations find First Nation peoples making continued and persistent efforts to establish self-government and to be recognized as the First Peoples of this country. Berry (1994) indicates that:

> "Social psychological theory suggests that under conditions of ignorance and fear, negative attitudes predominate....by providing information about Aboriginal self-government, a more positive attitude toward self-government could be brought about....feelings of cultural security play an important role in allowing individuals to accept self-government....knowledge and security combine to contribute to even more positive attitudes". (p. 228)

Negative attitudes toward people result in poor self-esteem and the subsequent outcomes indicate a greater likelihood of poor health.

4.1.2 Aboriginal (First Nation) Rights

A key barrier to resolving ambiguities in policies impacting entitlement for Aboriginal and First Nations is the conflict of the federal and provincial jurisdictions and interests. This is not unique to Aboriginal issues, but is prevalent in decisions on health, social and economic policy making. The key areas resulting in conflict for federal and provincial governments when dealing with Aboriginal peoples are 'land claims, self-government and financial liability'. (Boldt & Long, 1985, p. 347)

Land Claims:

The provinces must co-operate with the federal government in the negotiation of land claims for meeting treaty obligations. This results in opposition from other interest groups in the provinces, and is a particularly difficult and lengthy process of negotiation when it includes the rights to mineral resources.

As First Nations undertake negotiation of land claims settlements, awareness of the present system and anticipation of future systems in the management of services on those lands is critical. One key informant, a First Nation policy-maker, indicated:

> *"Our MLA for this area understands that we are Manitobans too, and that we should have access to provincial resources...we also need the help of provincial people identifying and helping us with our problems...with some of the lands in this area becoming reserve lands, right now they are provincial responsibility, but once they become reserve lands, then they become our responsibility and we'll need help with the province in those areas, sharing information and meeting regularly to share information."*

Self-Government and Health Transfer:

Self-government can be addressed through the transfer of programs, changes to legislation, and through political recognition of government status. The federal and provincial governments have not reached consensus on how to proceed with this issue. In addition, the federal policies do not support Aboriginal claims to inherent sovereignty (Boldt & Long, 1985). First Nation leaders recognize that the provinces have a significant role to play in program delivery. The uncertainty of the effects on treaty rights and historical relationships results in reluctant collaboration with the provincial governments. First Nations fear that:

> "by accepting financial and program assistance from the provinces they will undermine their traditional trust relationship with the federal government under section 91(24), thereby forfeiting their Aboriginal and treaty rights" (Boldt, 1985, p. 352)

The move toward Health Transfer through the transfer of health programs has had positive outcomes in terms of community autonomy. It has also had negative outcomes resulting from the ambiguity of established processes and protocols that define the relationships with provincial and federal governments. Residents have seen significant

turnover of health care workers, educators and other support workers in their communities. Long term commitment is infrequent, and therefore continuity in staffing does not occur routinely. Trust relationships between itinerant service providers and the community residents and leaders are difficult to develop. The ability of First Nation communities to recruit Aboriginal professionals is seen as a potential solution to retention of staff who are aware of the historical and cultural issues for First Nations (RCAP, 1996; CMA, 1994; Fricke, 1998). One key informant is a health care worker in his/her own transferred community:

> *"One of the reasons why I went in to nursing was that I thought the consistency in nursing services wasn't there....And just when the community people were starting to gain trust in that nurse, and the nurse was starting to know the people, they would leave....I always think that people will be more receptive to you if they know who you are, if they trust you."*

Initial transfer efforts have identified areas that require changes, and the need for clarity on roles and responsibilities is paramount for responsible program delivery. It is still evolving into an integrated system that meets the needs of First Nation peoples within an established provincial health care system.

Fiscal Responsibility:

The fiscal demands on the federal and provincial governments have resulted in conflict over the financial responsibility for services for Aboriginal and First Nation peoples. It is within the financial realm that 'jurisdiction' becomes a significantly contentious issue. A federal policy-maker stated:

> *"Jurisdiction primarily gets defined as who pays for what...the jurisdictional piece really does evolve around who's paying for what, with some parties at the table expecting others to pay for more, others at the table expecting folks to pay for what they believe is jurisdictionally theirs to pay."*

The federal government has transferred increasing responsibility for health and social services to the provinces with a resultant shift for First Nations health and social service delivery also to the provinces. Although some provinces do provide health, social and education services to First Nations on reserve (Maioni, 2002), Manitoba does not. A former Health Canada health care provider stated that:

> *"The main issue is a treaty-based issue...and because that's unresolved with the federal government, it's become unresolved with the province. So when First Nations are leery of dealing with the province, I feel that they should be, because you never know how that interaction with the province will be seen and how it will be abused or misused by Health Canada in their attempt for fiscal restraint...The other thing with jurisdictional issues is that when you look at how the government sets up their positions, it seems like the ones that can make an impact on fiscal restraint are the ones that get moved up the ladder...So these positions are used as a personal agenda and they're used as positions of power...they're rewarded for looking at the budget ...I see their main responsibility as keeping within that budget."*

Service has been affected by some decisions related to the fiscal constraints faced by government. A key informant who is a health care administrator and decision-maker summed this up:

> *"This is less about whether the right level of service is being delivered in the right measure at the right time to a client, and more about who's paying for it.....People are competing for resources...and one of the ways they can be successful is to shift the burden of past expenses from them to somebody else who they think more logically should pay for them."*

Concerns regarding the context within which decisions are made have been raised consistently. Health care providers have concerns about how jurisdiction affects the access to service. They stress that administrators and policy-makers must consider the need for, and quality of, this service when making decisions. This approach to these kinds of situations was summed up by an administrator in this way:

"When you focus on what the medical need is, when you focus on the client, when you focus on the community, jurisdictional issues become easier to deal with...The further removed you are from the community, the more there's a balancing going on between how you're expending your resources and addressing jurisdictional issues in a community and where you're at with your senior political folk...the closer you are to a treasury board, the more likely you are to focus on who is paying for what and jurisdiction."

The provinces have had particular concerns about their ability to meet the financial demands of universal health care in general. Financial responsibility for health programs for First Nation peoples is an additional expense that provincial governments feel that they actually can refuse, based on the principle of federal fiduciary responsibility for First Nations.

The move toward self-government has resulted in criticism from provincial and First Nations governments that the federal government is shifting financial responsibility for health and social services to other levels. Under the Health Transfer Initiative for First Nations, the federal government has indicated that the transfer will occur within the existing funding base, without additional support for the development of administrative and technological capacity. The potential affects for service delivery when faced with static financial resources would indicate a likely withdrawal or reduction in service. A key informant summarized it in this way:

"...you've got this dance going on between Health Canada and the First Nations saying 'well, we've only got this much money to do this' and Health Canada saying 'but we transferred the responsibility to the First Nations' and it seems to me there is a gap in there, a big gap, either the person doesn't fit, or the criteria doesn't fit, or the resources don't fit."

The Aboriginal peoples have a significant burden of illness, with infectious and chronic disease; and Manitoba has the largest Aboriginal population of any Canadian province (Statistics Canada, 2002). There are potentially significant financial

implications for the government of Manitoba in increasing their investment in Aboriginal and First Nations health care. A First Nations policy-maker indicated that:

> *"It's pretty clear that the design of government, of their policies, is to try and limit their responsibility, limit their costs as much as possible. I think First Nations people are at the very bottom end in terms of health treatment."*

The relationship between the federal and provincial governments has been acrimonious on a variety of financial fronts, the most significant being that of health and social services funding. Historically, health and social responsibility has been viewed as a personal responsibility. This forum, in particular, requires collaboration between governments to ensure a change in the health status of First Nation peoples.

Maioni (2002) indicates that the federal government must become more of an enabler in ensuring quality health care for all Canadians while assuring that provincial governments have sustained capacity to meet their responsibilities in health care. (p. 10) Managing the budget has been identified as a means of measuring the effectiveness of government, whether it be at the federal, provincial, or municipal level. It is a difficult balancing act to manage financial resources in a manner which demonstrates efficiency while effectively meeting the health, social and economic needs of the population it serves. Governments have had difficulty, also, in balancing the power that elected office brings with the expected accountability to their electorate.

First Nations and Aboriginal Peoples – Canada's Commitments

First Nation and Aboriginal peoples have traditionally not been a component of the electorate to which government has felt a need to be accountable. Concurrently, government will not risk commitments that would reinforce the perception among general electorate that the needs of First Nations are being met at the expense of the

general populace. This has resulted in a situation wherein both federal and provincial governments traditionally have not dealt with issues unless forced to do so through public pressure from First Nations and Aboriginal groups, and their supporters.

Many Canadians perceive First Nation and Aboriginal peoples as a sub-group of the population who have imposed a significant burden on this country, from a financial, moral and ethical perspective. The recognition of Aboriginal rights would acknowledge a level of responsibility to this population that is not acceptable, as it would imply a national responsibility for the wrongs imposed upon Aboriginal people over time. It would result in a level of social and financial responsibility that may not be supported by Canadians generally.

The historical ambivalence reflected in the failure of government to take a clear stand on First Nation and Aboriginal rights is a complex and convoluted situation. This has resulted in outcomes in health, economic, and social services including education and justice, that are unacceptable in a country such as Canada. Some systems have been affected by greater negative outcomes than others, and initiatives to address these injustices must acknowledge the rights of First Nation peoples to participate as full and equal partners in identifying strategies for, and reaching solutions.

4.1.3 Access to Service

Ability to access health services may be less of a concern for individuals, than the actual process of gaining access to services. The historical development of services for First Nation peoples in Canada have resulted in assumptions of how the system works, and how the services are funded for First Nation peoples by the federal and provincial governments. There are complexities in collaborating with geographically remote

communities who receive primary care services from itinerant medical and nursing staff. MacMillan et al. (1996) note that:

> "Aboriginal people have less access to health care services than other Canadians because of geographic isolation and a shortage of personnel trained to meet the needs of the native population. Approximately 30% to 50% of Aboriginal communities are in remote regions, many accessible only by air." (p. 1572)

The degree to which individuals are comfortable with service delivery depends on many factors, including the ease of access to the system.

The health status of a population is the result of influencing factors of many health and social determinants. While access to health service is important, this alone does not result in improved health status. Personal health practices and a personal sense of control in decision-making for dealing with everyday challenges are key determinants of health (F/P/T Advisory Committee on Population Health, 1994; Frank et al, 2003; Health Canada, Towards a Common Understanding, 1996). It is clear also that negative attitudes resulting in negative behaviours directed towards a population can result in a loss of self-esteem. When these negative attitudes or behaviours affect access to service, and subsequently one's personal decisions and sense of control, this will have an affect on health status. A First Nations health care provider in a transferred community commented that:

> *"People have always had difficulty in getting services at the clinic or at the hospital. There's always been problems, we know that Aboriginal people have never been treated very well at the hospitals and clinics, and it stems back many years, but it's still there. And even with the provincial office having all these services available, like mental health nurses and psychiatrists that may come and visit, the hearing audiologist and the speech therapist, all those speciality people that come through the province, those same services are not as easily available to our First Nations people. We are not a priority for appointments, it's very difficult to get appointments for our people. And even with the DER (Diabetes*

Education), the non-status communities are their priority, and it's very difficult for us to get appointments for people....I know that comes from the thinking that has always been there, that the province does not service First Nations people, or people on-reserve."

When a population has poor health status, there must be concerted efforts to address the relevant determinants of health through inter-sectoral collaboration in order to effect change. A provincial system decision maker indicated that:

"We see as a mandate, inclusion of Aboriginal people in the health service delivery system, not necessarily to do the same old thing, but there is every evidence to tell us that there should be special strategies, unique approaches, all of that kind of thing to ensure access and appropriate delivery to Aboriginal people.....I don't know whether there's a gap in service, or there's perceptions about the gap, but I guess at the end of the day, it may be both..."

There may now be some forward movement occurring as a result of recent initiatives and dialogue between the federal, provincial and First Nation governments in Manitoba (Romanow Joint Working Group, 2003).

Public Health Services for First Nations

Public health situations are frequently the most likely to involve jurisdictional ambiguity, and there are a variety of perceptions or understandings expressed by stakeholders explaining this discontinuity. Public Health is governed by both federal and provincial legislation. There is lack of clarity in authority over the enforceable legislated functions in public health on reserve. This lack of clarity results from uncertainties in the interpretation of the Constitution Act, the Indian Act and the Public Health Act.

Recent crises in public health have raised our awareness of the on-going need for vigilance in public health monitoring and surveillance of disease. The integrity of public health infrastructure such as water treatment systems and programs, and monitoring and surveillance programs will minimize susceptibility to known communicable disease. The

deaths and illness that occurred from E. coli in contaminated water in the Walkerton, Ontario situation in 2000, emphasize the need for strength in these systems. The emerging threats of diseases such as West Nile Virus and the highly infectious Severe Acute Respiratory Syndrome (SARS) highlight the need for established systems in monitoring and surveillance as well as effective national and international communication systems in public health.

Health transfer involves the transfer of management of mandatory programs such as public health and immunization, environmental health and disaster management. First Nation communities and Tribal Councils undergoing health transfer must establish a new system that facilitates collaboration with the provincial government. This dual collaboration alters the present system existing prior to completion of health transfer where the First Nations collaborate exclusively with the federal government, and the federal government collaborates with the provincial government. Often, the specific need for this collaboration is not apparent until there is a crisis, and health care administrators and providers must reach out for assistance in resolving the situation. A key informant in a transferred community commented on some gaps in the communication systems:

> *"Ever since we've had health transfer, we don't have that same kind of contact with the zone nursing officers (federal) that we did before. It's like they leave us out in the dark. There's nobody giving us updated information on things that are changing... There's nobody keeping us informed as to the changes that are happening. We should be informed as to whenever there are meetings going on with Medical Services."*

In commenting specifically on the relevant protocols for Public Health, the health care provider stated that:

> *"When those health transfer agreements were negotiated with First Nations, I think that the Federal people, or Medical Services should have advised First Nations communities that these are very important things to*

have in place so you can have consistency in the professional people that you are hiring."

The roles of public health staff on reserve – nurses, public health inspectors, and medical officers of health – and how they interact with each other in various public health situations must be clearly documented to assist staff in responsive processes:

> *"The province and the provincial MOH and the federal MOH, they need to communicate a lot closer. They need to establish that communication link and they need to agree on what will be done, and that they would notify their contact person at the provincial office here.....as long as it's clearly set out what will be done....I think it should have been included with transfer, clearly stated in the health transfer agreement how that will be done so that everybody knows and that, when FNIHB is signing, they know what the agreement has been."*

The potential for increasing incidence of crisis situations in public health (and the resultant risk to individual and public health) is significant if public health staff are unclear on how to access assistance within the system during an urgent situation. Communicable disease and environmental health crises do not occur in isolation. As illustrated in the thematic framework (Figure 1), First Nation communities are an entity within Regional Health Authorities in the provinces. Risks to the health of the general public are potentially as great if an incident begins on reserve, or if an incident begins in a rural town or municipality managed by the province. Conversely, the risks to the First Nations exist from emerging threats in communities off reserve as well as those arising on reserve.

Environmental health situations arise frequently, usually pertaining to water quality and safety. A long standing issue for concern is the documented deficiencies of water systems in many First Nation communities (The Tribune, November 17, 1979, p. 4; Winnipeg Free Press, July 12, 1994, p. 1; Winnipeg Free Press, May 15, 2003; AFN,

2003, pp 5 & 9). Following a series of emergent situations with water systems in several First Nation communities in 1994, the Winnipeg Free Press documented:

> "...Chief Francis Flett said the main problem for many northern reserves is that there was little planning when water systems were installed. By the time the (...) system was completed seven years ago, the reserve had already outgrown it"(Winnipeg Free Press, 1994, p. B3)

Limited resources are available for dedicated funds for the initial installation of new and upgrading of old sewage and water systems. In May of 2003, the federal government committed $600 million over five years to address deficiencies in water systems on reserve, which is to be shared between 691 First Nation communities nationally (Winnipeg Free Press, May, 2003, p.A3; AFN, 2003, p. 9). Communicable disease outbreaks frequently follow breakdowns in the integrity of water systems on First Nation reserves. The need for established communication systems between jurisdictions is necessary to minimize health risks to the public.

Ambiguity results when attempting to address disruptions to healthy environments in First Nation communities. The scope of the public health and environmental health programs, and the relevant applicable legislation, is poorly defined across jurisdictions. A key informant expressed frustration over the need for clarity in protocols:

> *"..the biggest difference is obviously the program mandates of the provincial governments versus the First Nations. They've got policies and protocols, they've got laws and they've got enforcement tools. And because of all those types of programs using the Public Health Act and the Environment Act to get the province to do their job, they have to have definitive program delivery so that there's consistency in how those programs are developed....we are transferred, we are on our own....there has not been a strong link with keeping in touch and making sure that we get everything we need to operate....the environmental health program was mandatory, but they did not make the medical officer of health program mandatory and that has hurt."*

Following health transfer, protocols defining the program linkages and responsibilities are beneficial for the monitoring and surveillance of risks to health. Accepting appropriate responsibility for infrastructure development and maintenance requires committed communication efforts by various departments of government, both federal and provincial. One policy maker and health administrator commented that:

> *"At the end of the day, the Minister of Health is responsible for health. Now that doesn't take away our individual and collective responsibilities, but when it comes to policy and funding for health, the Minister of Health is still on the hook....so I don't understand how Health Canada can walk away and say: 'Oh well, we've transferred that to the First Nation, it's now their responsibility.' Well, it may have the responsibility to operate the service, but does that take away all of Health Canada's ultimate responsibilities..."*

Health care providers, with responsibility for the individual client or for the collective public, are on the front lines attempting to manage crises as they occur, and established networks of communication are important to begin the process. A health care provider, as a key informant, provided insights on key issues:

> *"When it doesn't work, it's usually if there's ambiguity about who's the lead. Most people in a crisis just do the work. And that's what's good about it. I think if we had more clarity, and I would indicate more internal clarity than external clarity, in our own organization....Frequently, it's a difference in the perception of what someone's role is and what someone else thinks their role is. There is secondary gain in not clarifying that, because then it might become someone's primary responsibility. So there's a lot of secondary gain in keeping something ambiguous, in my opinion....By keeping it ambiguous on both sides, and having some one saying 'we assumed that you had your own plan' is really naïve at best...we shouldn't assume that our neighbors have a plan in a public health crisis, or in any infectious process....that's foolhardy."*

Conflict between staff in the respective jurisdictions can arise as well, and this has an affect on the timeliness of the response to public health emergencies.

The need for urgent, timely, and co-operative intervention in preventing outbreaks such as SARS is well documented. A recent incident which could have had potentially very serious outcomes, not only for First Nations on reserve, but for non-Aboriginal peoples in the vicinity involved the need for collaboration between Public Health staff of provincial and First Nation jurisdictions. The unfortunate response of one individual to this collaborative effort is concerning, in terms of public health safety:

> *"...one of the provincial health nurses phoned that nurse and told her: 'why are you coming to discuss your situation with our medical officer of health? This is a provincial medical officer of health and you shouldn't even be talking to him/her. You have your own medical officer of health - you were given lots of money under your health transfer agreement to hire your own, so don't come here.' So at that point, that nurse felt isolated and she didn't know who she should be contacting."*

This subjective response to a potential public health emergency is a reflection of the more serious underlying issues in health service delivery across jurisdictions:

> *"We've had various situations where we had to contact a medical officer of health...at that time, it was the MOH of Medical Services...s/he said: 'you know that you're a health transferred band and I shouldn't even be here to help you with this, but you need help'....and I thought, well who's supposed to be helping us then, because at the same time the province was saying the same thing to us....we had one MOH with the province – he was new to the community at that time, so I don't think that he had been conditioned, he was open to helping....also, there were cases off the reserve as well as on reserve, so he had to be involved."*

The poor health status of First Nation peoples, in Manitoba as in all of Canada, with the accompanying burden of illness, is a daunting image for health care planners and providers. One health care provider summed this up as follows:

> *"We are not the Bermuda Triangle in the middle of the RHA's, you know, just little holes that drop in to the earth. I think our issues are scary to the province, and to the medical officers of health. They don't have the huge burden of illness in public health that we do, and it frightens people, I think. And they don't even know, some of them, what to do about it, or if they should. It's just nice for them to know that someone is doing it. But*

you try working in a place where each one thinks the other person is responsible. It's quite frightening."

The ambiguity that exists around health program delivery for First Nation peoples on reserve, particularly in public health, does not lend itself to easy resolution. Efforts to solve problems and to work through management of public health situations are generally the result of cohesive partnerships, whether temporary or sustained. One key informant who has served as a health care provider in First Nations communities indicated that:

"People aren't unwilling to do their jobs, they just want to know if it's their job or not...it seems most people do the right thing and whether they have to preface it with 'it's not really my job, but...'... I think some people play well with others, and some don't...public health people generally play well with others, and you grudgingly do what you shouldn't do, but you feel good because you solved it together...Public health people are frequently the kind of people who say 'I don't know the answer to that but I'll find out' which is different from bureaucrats who say 'I don't know' and hang up the phone...It's really the top people who are the problem. We make it a problem for the people."

Decision-makers in health policy development and health program delivery have the responsibility of resolving these potentially critical issues and relaying clear directives to front line staff. The need for inter-jurisdictional problem solving is important for maintaining public safety.

Public health is an area where the potential implications of emerging situations posing a risk to health are clearly relevant to the entire population. The far-reaching affects of a communicable disease such as SARS, is an example of how small our world has become. Although First Nation peoples were devastated as a population with the initial influx of infectious diseases that arrived with the Europeans; Canadians generally, now have the same risks for infection by the new and emerging diseases as do First Nation peoples. The perception of defined borders between federal and provincial lands

is not valid in public health and environmental health. The obvious need to collaborate on the management of health services to minimize health risks to all Manitobans, and all Canadians, is exemplified by the SARS experience. As one health care provider had indicated earlier – assumptions that others have a plan to deal with public health crisis is foolhardy at best.

Primary Health Care Services

Although people prefer to access service as near to home as possible, discussions on solutions for achieving this goal did not include First Nations, and were not necessarily a priority for government. In Manitoba, in 1964, a Memorandum of Understanding (Appendix 1) was drafted between Health Canada and the Province of Manitoba, to carve out geographic areas for responsibility of health care. This has had residual affects on overall health service delivery, in primary care and public health.

The access to service, and range of service provided, has been cause for concern in the communities affected by the 1964 Agreement. One key informant stated:

> *"So as a result of '64, we've got, probably the federal interpretation of what services they need to provide in the communities they're providing them in. And we've got provincial interpretation of the services that Manitoba has put in place. There's discrepancy between both services."*

The discrepancies noted in service variables result from the lack of clearly documented joint service provision for the on- and off-reserve health programs for First Nation peoples. Discrepancies include examples such as diabetes education and audiology services which are provided in 1964 communities such as Grand Rapids and Easterville that are the responsibility of the provincial government, but not in Norway House or Cross Lake, communities that are the responsibility of the federal government.

A concerted move toward integrating services with enhanced co-ordination of service delivery requires inter-governmental participation and commitment. The First Nation peoples have a long history of lack of trust in the federal government. The provincial governments also are cautious of the federal governments' intent around financial and social responsibilities for the health and well-being of First Nation peoples. Recent collaborative efforts between a First Nation government, federal and provincial governments have resulted in positive outcomes for a service delivery model in a remote area [Manitoba Health, Health Canada, Island Lake First Nations Memorandum of Understanding, (MOU), 2000]. A key informant from the federal government had this perspective:

> *"I'm not sure that the right levels of trust are in place yet. I think we're seeing some clear signals in terms of political will to want to move towards some more integration. I think that in order for integration to work properly we actually have to do something that we have not done particularly well, and that is really meaningful consult with First Nations about what this means, about how we intend to do things, and to relay any concerns that almost inevitably emerge when we have these conversations around somebody trying to escape from their responsibilities....If you're living in the (XXX) Health Authority now, one of the things that you see as a result of integration is people don't have to leave their communities to get dialysis. Nobody is walking away from the table."*

Chronic shortages of medical and nursing staff for service delivery in remote First Nation communities have historically resulted in problematic situations for primary care. Even in times of adequate levels of medical staff in the province, recruitment of physicians and nurses to the northern First Nation communities has required special efforts. As has been the case in past recruitment and retention efforts, assurances of career security and benefits for staff are variables that First Nation communities involved in post-transfer recruitment initiatives will need to address.

Primary Health Care Models

The communities in northern Manitoba have had itinerant physicians provide service under contract to Health Canada's Medical Services Branch administered through the Zone office in Thompson in the past. The federal government had greater difficulty recruiting itinerant physicians to the southern remote communities, and recruiting physicians to the hospitals in some First Nation communities. Other parts of the country had seen successful initiatives in physician recruitment through the universities in conjunction with government. The federal government and First Nation communities in Manitoba contracted the University of Manitoba (J. A. Hildes Northern Medical Unit) to provide physician services in difficult-to-serve areas.

Although not truly a collaborative effort, the contract for this service delivery was joint funded between the federal government and the provincial government. The province provided the funding for physician and specialist fees in the communities, allowing the recruitment of salaried physicians. The federal government provided the funds to support the physician practice in these communities, including physician access to communities. The University was expected to meet their deliverables in this contract, despite a lack of agreement on the scope of financial responsibility of the two levels of government. First Nation communities were not involved as negotiators or signators in the process. As a result, funding was dependant on the ability of the university administrators of the program to negotiate a package that met the priorities of the regional federal and provincial health administrators. A disconnect between the need to marry financial responsibility to best practice philosophy in health program planning has

resulted in an absence of funding for activities usually established as routine standards in medical practice – such as diabetes education and access to screening programs.

Both federal and provincial representatives, respectively, express concern over the lack of on-reserve screening programs, and the lack of funded transportation to access off reserve screening programs. A key informant working as an administrator in the federal system expressed frustration:

> *"First Nation peoples are also citizens of the province. And the fact that they choose to live on a reserve community shouldn't eliminate them from eligibility for programs that are available to every other citizen of the province. But in fact, screening is a good example, that's what occurs....I could go to the edge of my jurisdiction and say 'can you be more flexible about scheduling because if we're bringing people up for other purposes then we schedule breast cancer screening at the same time. If we can find a way to get you into a community, would you go? And the answer is 'no'. Now, why not?"*

A health care provider also expressed concern about the lack of a cohesive approach to working within the guidelines of medical practice for addressing some of the very serious health issues within First Nation communities:

> *"A good starting point would be a clear document that identifies what the federal government believes their responsibility is. A companion document should be what the provincial government feels they should be responsible for. And to follow up those two documents would be the two government levels meeting to determine what the gaps are and having the decision as to who should close the gap...This should not be done on a Manitoba level; this should be done on a national level in part to harmonize programs between jurisdictions, between provinces and territories, to know exactly what the responsibilities are of each government regardless of where we're operating in Canada."*

Federal and provincial administrators have recognized the need to coordinate activity to address these gaps. A mechanism for doing so has not been entrenched in a collaborative approach to integration of services.

Recent movement in the integration of services for all Manitobans, including First Nation peoples, have resulted in some positive initiatives aimed at addressing health status disparities. First Nations have exhibited a degree of caution when moving ahead as a partner. A federal decision-maker indicated that:

> *"First Nations communities...get very concerned when you talk about integration, and what they hear is the federal government seeking to withdraw from its Treaty obligations as opposed to thinking abut it as a new way of satisfying the Treaty obligations."*

The traditional approach to integration did not necessarily include dialogue with First Nations.

A commitment to change must include efforts for the development of effective programs with public policy that meets the needs of First Nation peoples. This must include not only public policy in health, but also social policy that influences health and social services development. When establishing programs that will meet the specific needs of Aboriginal peoples, common problems which emerge on a consistent basis (Hylton, 1994) include:

- inadequate financial resources;
- financial support is short term;
- a crisis management focus;
- inadequate infrastructure development; and
- uncertain roles and responsibilities (paraphrased from p. 44).

One mechanism for ensuring that programs meet the needs of First Nation peoples and will be sustainable and appropriately funded, would be through the process of self-government. The efforts of the Island Lake Tribal Council in reclaiming authority and autonomy for their communities governance and service delivery have been identified as

positive initiatives of a collaborative nature between the four Island Lake communities and the provincial and federal governments (Manitoba Health, Health Canada, Island Lake First Nations Memorandum Of Understanding (MOU), 2000):

> *"To my knowledge, the Island Lake area in Manitoba is the only area that has a process in place to look collaboratively at health-care programs. And that collaboration is community, federal and provincial. It does not include the provincial regional health authority that the communities are within, but it does include provincial and federal jurisdictions within the communities – and not just health. It also includes other jurisdictions federally and provincially that have an impact on the integrity of health in the communities, including the federal and provincial departments responsible for infrastructure in northern and First Nation communities."*

Although the identified Memorandum of Understanding deals specifically with the delivery of health services, the underlying concept of control of decision making is a key determinant of overall health status of a population. Other Tribal Councils in the province of Manitoba have assumed various levels of responsibility for health service delivery, as well as economic development, social services development, education and justice initiatives. Integration with provincial programs on a regional level has been effected through various degrees of involvement and commitment to partnerships.

O'Neill and Postl (1994) have indicated that:

> "self-government will constitute an enormous step in breaking the cycle of poverty, disadvantage, and hopelessness that now causes an extensive burden of illness in Aboriginal communities. While self-government will improve the effectiveness of health care services, its more important result will be to prevent the causes of ill health in the first place." (p. 83)

4.2 JURISDICTIONAL RESPONSIBILITY IN FIRST NATIONS HEALTH CARE

Establishing clarity on the responsibility for First Nation health and social services has become a complex undertaking. We have reviewed some of the potential reasons for the presence of ambiguity in jurisdictional responsibility for First Nation health programming. Not only are co-ordination of national health and social policy development needed, but also, efforts are needed to ensure that the policies on First Nations affairs are not contradictory to similar policies at a provincial or federal level. Complicating efforts to address jurisdiction is the underlying impression that the federal government has continued its assimilation efforts despite the First Nations commitment to self-government. As Comeau & Santin have stated:

> "the White Paper simply went underground, and continues to be the main driving force behind the government's native policy" (Comeau & Santin, 1990, pp. 16 - 17).

The process undertaken by the federal government in developing the First Nations Governance Act would appear to support that concept.

The constitutional division of jurisdictional powers has had implications for federal/provincial relations in situations that pertain specifically to First Nation peoples on and off reserve. A First Nations policy maker made the observation that:

> *"The BNA Act...was probably the beginning of the derailment of our treaty right to health...and the division of powers, I think, certainly fail to recognize the jurisdiction to health matters resting with the First Nation communities, along with our Crown partner...there was already recognition of major epidemics...it was one of the significant reasons why they continued to say that the Crown would have a medicine chest that would provide for First Nations people...the federal Crown has to recognize that First Nations people must be given responsibility at some point in time...They have their own jurisdiction...they must be in control of their own treatment programs..."*

For government to have a true understanding of what would constitute effective and relevant programming, the First Nation peoples must be involved in the development of health and social programs for First Nation communities.

The establishment of a universal health care plan removed some of the mandated health care responsibilities for governments on services for First Nation peoples. The ongoing concerns regarding the sustainability of this universal service have affected the health programs and health benefits available to First Nation peoples through Health Canada. A provincial health care administrator noted that:

> *"...part of the challenge to begin with, is making sure that everyone is on the same page with the basic principles of what is expected...you know it's still not clear, depending on who you talk to within either system. What is the understanding of roles, responsibilities, legal, political, administrative and otherwise, to meet the health needs of First Nations people living on reserve? And there are lots of reasons why that's difficult. Part of it is, what do we mean by health needs? Are we just talking about health care, are we talking about insured health-care benefits as we know them within the Canada Health Act and within the Province of Manitoba? Are we adding on non-insured health benefits? Are we adding on public health? If we're adding on public health, what do we mean by public health? Do we mean just the delivery of programs and services within various specific mandates like vaccination programs, or do we mean population and public health, which means environment and the social and economic determinants? So we have to start off by defining all these terms."*

With the decrease to the federal share of health care funding, and the implementation of the Canada Health and Social Transfer (CHST), concerns regarding the adequacy of health care funding emerged. Provincial governments struggle with the need to contribute tax dollars to sustaining a health care system that is enforced by the federal government through the Canada Health Act (Lazar et al, 2002; Braen, 2002). The systematic off loading of federal funding responsibility to the provinces in health and social services has included provision of these services for First Nation peoples as well.

The Manitoba government established the "Working in Partnership - Manitoba Policy on First Nation Government" in 1999. This publication states:

> "To date, the Manitoba Government has not been invited to participate in the formal discussions between the AMC and the federal government...." (p. 6)

However, the government went on to indicate that the policy was based on principles that the Manitoba government recognized the culture and history of First Nation peoples, and supported the concept of working in partnership. The policy was based on the assumptions that First Nations rights are constitutionally based, and that only the federal government had fiduciary obligations over the assets and affairs of First Nation peoples. The key issues in the policy are summarized as (Manitoba Health, 1999, p. 9):

- re-statement of the provinces participant role in negotiations on issues affecting the province;
- Manitoba will ensure that the shift of federal responsibility to the First Nations will not result in further shifts to the province; and
- expressed conviction that the federal government must place more emphasis on health and social services for First Nation peoples in order to affect a change in health status.

Concerns by provincial governments regarding funding cuts by the federal government have resulted in the refusal to provide services to First Nation peoples on reserve for fear of further off-loading by the federal government. One key informant stated:

> *"I see the province, sometimes they're caught in the situation about going on-reserve because they have to be careful that the feds are not off-*

loading to them. And it's a legitimate concern for them as it is for us, too...there needs to be an understanding, and I think it needs to be recorded...those are the kinds of things that interfere ultimately with service to the First Nations."

The examples below are reflective of personal experiences in different health care areas where health care providers have been exposed to the covert policies of limited service for First Nation peoples:

"The new community nurse resource center...was established...they have three nurses and the nurse practitioner...and they've been very supportive whenever we've asked them to do joint education sessions, but at the same time I know that they're being told that they shouldn't be doing that, because they told us that before, that they were told that, but they continue to be supportive."

"In mental health the provincial people first off would not go on-reserve to provide the services. We had people in...who wanted access to mental health resources and the only way they could access it was if they came to the town and went to see the staff at the provincial building."

"They have workers in there that promote that position that jurisdiction...I remember seeing their policies when I was with the health center, and the workers were not allowed to go on, or work on reserve."

In addition, the First Nations are reluctant to engage in negotiation for provincial health services in the event that this activity may diminish their treaty rights. In discussing national and provincial health reform and the effects of regionalization for First Nation peoples, a health care provider reflected that:

"...my perception, at least from my perspective, is that, in general, First Nations are not well involved, and perhaps are not well informed about the agenda for regionalization and how it would improve delivery of health services from a provincial perspective. Again, I suppose the politics becomes involved there, because the responsibility for First Nations health, I believe, is seen as a federal responsibility, and again having the province involved somehow might be seen as weakening that relationship."

The federal government has systematically cut back on the federal percentage of funding for health and social services in transfer payments to the provinces. This has

resulted in some caution by the provinces in the area of health service planning and delivery; particularly in areas for which they have not received specific funding, such as First Nation health.

4.2.1 Barriers to Service in First Nations Health Care

The division of sovereign powers under the constitution has resulted in the need to assess the integrity of federal/provincial relationships when reviewing responsibility for First Nations health care. The funding of health and social programs for First Nation peoples has historically resulted in limited support from the provincial governments. The approach of federal funding for universal health care has allowed the provinces discretion as to the degree of coverage they will provide for First Nation peoples on reserve (Fricke, 1998; Lazar et al, 2002; Weaver, 1985). Variations across the country can have significant affects on the comprehensiveness of service for First Nation peoples. Home Care is one service wherein Manitoba has made a policy decision that they will not provide this service on reserve (Fricke, 1998). Indeed, the provincial government does not provide any direct service on reserve in Manitoba, except in communities identified under the 1964 federal/provincial Agreement as being the responsibility of the provincial government (Memo, Chief Medical Officer of Health, Jan, 2003). A former decision maker in First Nations health indicated that:

> *"The provincial government did not see that it had a role in Aboriginal communities, so when the homecare program was initiated in the early 1970's, that program was only established in northern and rural Manitoba. It was not established in First Nations communities. And in fact, it's taken about until 1999/2000 before the federal government actually began to establish a homecare program on-reserve. I think we saw the same thing with the diabetes education programs. There was a modest program established in the province in about 1984-85 whereby some resources were placed in all of the regions around Manitoba,...So I think that what you see there is a discord of the need as seen by the*

provincial government, and the needs as seen by the federal government, because there wasn't agreement and because the provincial government has always taken the stance that they do not provide on-reserve services..."

Historically, it has been difficult to establish a process for dialogue in resolving situations as it requires multiple departments in the federal and provincial governments (i.e. Health Canada, Indian and Northern Affairs Canada, Manitoba Health, Manitoba Family Services and Housing). Oftentimes, the same issues are recurrent, primarily because the process for resolution has been dependant on individual accommodation and not on the establishment of policy guidelines.

A specific situation requiring inter-disciplinary, inter-governmental and inter-departmental involvement relates to the resources for children in urban areas with complex medical problems and complex needs. These First Nation children may be in hospital awaiting discharge, or may require specialized care in medical boarding homes available only in urban areas. At the federal level, Health Canada provides for medical benefits and the Department of Indian Affairs provides social supports. At the provincial level, Manitoba Health provides insured health services, and Family Services and Housing provides social supports and services for Manitobans. In the past, First Nation children with complex needs in the health and social services areas often languished in hospital while the federal and provincial departments responsible for services were unable or unwilling to make decisions on how to provide care for these children.

Recent efforts by these government departments to facilitate a solution to this persistent situation have been encouraging. The extensive inter-disciplinary approach to coordination at multiple levels, has had full collaboration of senior administrators. One policy maker shared the perspective of the individuals involved in the resolution process:

"I think probably what didn't work is that we all felt entrenched, (we meaning the government service delivery bodies), entrenched into our traditional 'that's federal responsibility, no that's a family services, it's not a health responsibility, oh, that's a native affairs responsibility, that's the responsibility of whoever...right?...So in the meantime, we've got these few kids... where I say...Indian Affairs, Health Canada, RHA, and Family Services have come together around these kids, around this process to plan for them, to look at their needs, try and identify what the needs are and try and put them in context, everybody's context, but at the same time, try to define our resources, match the kids to the system so that the resources can be applied...Now that's sort of a goodwill...Whether or not that kind of goodwill will actually move to a significant policy change...that I suppose if we have enough and these systems work, maybe we'll get systems change...But right now, it's based on goodwill."

Health care administrators or providers appear more comfortable with the status quo – identifying the gaps, or barriers to a service rather than working toward a solution. Another health care administrator familiar with the process stated that:

"...the issue wasn't a new one and everybody was coming at the issue, frankly from my perspective, in a fairly confrontational kind of way. It was all about trying to force folks from one jurisdiction to do something that they didn't have the mandate to do...the biggest barrier in all of this was trust, an inability, or unwillingness to believe that other parties could come to the table and would be prepared to work through some of these issues... the absence of trust wasn't rooted in personalities; it was rooted in, sort of, the history, that promises had been made and hadn't been kept."

Establishing support systems in the community for children with complex needs requires a concerted effort by many. When asked if the process of collaboration had identified any systems barriers that needed to be addressed, an administrator indicated that:

"An example of one of those that we identified was when Indian Affairs came to the table with their goodwill, they realized that their policy, in terms of special needs kids could not be defined in health context...if you look at the kids as a whole, the health issues may be the driving issue, but other typical issues followed that..."

It is rare that high level administrators must gather to discuss specifics of case management, as this is usually accomplished at the level of the service delivery. The entrenched perceptions of both the jurisdiction and the mandate for service frequently results in misinterpretation at the service level, and this can have varying results. The above noted situation had been re-visited several times, with different individuals, but a legacy of difficulty in inter-departmental and inter-governmental relationships – primarily at the service level – was the key factor in determining the need for a new process to case management.

Relationships between the provincial and First Nation systems in health and social services remain largely uncertain – partially as a result of the outstanding issues around the Treaty right to health, and partially as a result of the historical resistance by the province to accept responsibility for service provision on reserve. When asked if services are well coordinated and integrated between regional and tribal council level services for First Nation peoples, one health care provider indicated that:

> *"...there's a philosophical gap there that's often difficult to deal with when it comes down to a service at the ground level...Often the political decision-makers don't have the kind of knowledge of health care that may be required to do a more complete planning, and it's impossible in any small community to fund and plan for all contingencies, that some things need to be done a much more systems level to be practical and responsible..."*

Clarity on the scope of Aboriginal and First Nations rights is critical to the development of First Nation solutions for First Nation peoples. Weaver (1985) states that:

> "federal resistance to these demands lies as much in the culture of policy-making (the liberal-democratic ideology and static concepts of ethnicity) as it does in the social roles (activist personalities and motivated ministers) and social structures (organizations, co-ordination, and jurisdiction) of policy-making." (p. 147)

The approach to public policy development on social programs tends to focus, not on outcomes, but on how to coordinate them so that they cost less. Cutting these programs would have significant negative effects on the health system, particularly with the focus on health reform and concept of a community support system as the mainstay of this reform. Manitoba studies (Martens et al, 2003) have indicated that, in general, First Nation peoples utilize physician services and hospital services in greater numbers than non-Aboriginal peoples. The health status is poorer and continues to worsen in some areas of the province (Martens et al, 2003). It is tempting to conclude that this implies a comprehensive system of access for First Nation peoples. It is also quite likely that the social systems and supports contributing to health status are as inaccessible to First Nation peoples as are appropriate health systems that would have an impact on health status. A health care provider in a First Nations community stated that:

> *"If you look at what's going on in our communities, we have more access to physicians and drugs now than we ever have, compared to 30 or 40 years ago, but we're sicker now than ever. So the physicians and the drugs aren't going to make us healthy. It's addressing the issues of the effects of the oppression, the low self-esteem, the chronic sustained anger at what's happened, and those things that have made people physically sick, the change in diet, the change in exercise. Those are the things that we need to be looking at and trying to fix, so you can fix the core of the problem, not just doing bandaids like giving out hypoglycemics and antihypertensives..."*

Integration of health and social services has not occurred routinely. A health care administrator noted that:

> *"...people tend to retreat to their jurisdictions as a first response to these issues rather than looking at acknowledging the jurisdiction issues and dealing with, how do we close the gap?"*

Funding for these health and social services continues to be 'silo'ed' within federal and provincial departments. Collaboration between governments or government departments

is often forced by crisis situations, as is evidenced by previously noted examples.

4.2.2 Fiscal Responsibility

Financial responsibility is a relevant issue when government departments begin the process of defining their mandates for service provision in health and social services. Communication between systems is poorly established and not well fostered. Health service delivery for First Nation peoples is fragmented. The government systems calculate the financial bottom line for their piece of the services to Aboriginal people independently, and each appears to feel that they are carrying the greater burden of health care expenditures. Estimated per capita expenditures for First Nation peoples can be skewed when presented on a provincial and regional level, if not broken down into all of the separate components. An example would be the estimation of total health care costs that include medical transportation. In Manitoba, including the medical transportation costs would greatly increase the per capita costs for this region, as there would be significant air fare costs due to the many isolated communities (Appendix 10, Table 11). The actual per capita costs for health care services, not including transportation costs, would be quite different. Ultimately, regardless of how health care costs are calculated, considering the burden of illness carried by First Nation and Aboriginal peoples, the financial costs for health service delivery for First Nation peoples will be high.

When looking at the real costs of health service delivery, the administration and infrastructure costs of program delivery may not be accurately reflected in budget estimates. This is problematic for First Nations undergoing health transfer, as transfer is to occur within the existing funding base. Program administration and management has been managed centrally. The need to provide administrative and management support at

multiple locations potentially increases the overall costs to health program delivery through the need for additional human resources and infrastructure development.

The "Insured Health Services"

Insured services in health care include physicians services, hospital services, and all diagnostic or hospital based support services. Costs of these types of services are driven by the utilization rates within a province, and remuneration for service providers.

The federal government provides health and social services funding through the Canada Health and Social Transfer (CHST) payments to provinces. The CHST is a block funding agreement that makes no distinction as to the amounts designated for health, education or social services. The federal government systematically decreased these transfer payments over a period of years by a total of more than one half of the total payments (Manitoba 2002, Budget Papers, p. C6). In Manitoba, in 2002/2003, the CHST transfer payments for health contribute 11.6% of the total provincial health care costs (Manitoba Health Presentation to the Joint Romanow Working Group, 2003; Manitoba, 2002). The federal government has announced that it will increase the portion of CHST funds for health care to 62% of the total funds, bringing the contribution to 16% of total health expenditures for the province – this action will be at the expense of other social programs (Joint Romanow Working Group, 2003). The federal government has also announced a five year, $1.25 billion program for First Nations and Inuit Health for on-reserve initiatives in capital and programming.

The CHST funds continue to be determined by the federal government unilaterally, and are inadequate for the anticipated needs of the provinces. The provinces hold to the principle that federal funding for health and social services should be formula

driven, based on need. A study by Prof. Ruggeri – "A Federation Out of Balance" was updated for the federal government and premiers in 2001, and has indicated that the federal resources are sufficient to assist the provinces in sustaining universal health care. The study indicated, however, that:

> "there is a need for fundamental change in intergovernmental fiscal relations aimed at rebalancing the fiscal structures of federal and provincial government in a manner that allows both orders of government to fulfill their constitutional spending responsibilities in a fiscally responsible manner and in a manner that respects jurisdictional integrity." (Manitoba, Financing Health Care, Budget 2002, p. C7)

Manitoba has taken the stand that:

> "The current model for establishing priority and responsibility in respect of health and other social programs is dysfunctional" (Manitoba 2002, Budget Papers, p. C9)

The funding under the CHST is deemed to be inadequate relative to the actual expenditures. The federal government funds the provinces on a per capita basis, and therefore remunerates for costs that are well below the actual costs of service delivery. First Nations have long argued that the province receives funding for all First Nation peoples in the province but do not provide service on reserve. A First Nations individual involved in policy and decision making stated that:

> *"I certainly believe that the provincial government has a responsibility to First Nations people. I think they should be able to access funds through the Canada Health and Social Transfer. They include the First Nations populations into their censuses and they receive money to provide health services. At the same time, we live in this province, we pay taxes in this province...and I think based on that factor alone, they have a responsibility to First Nations to bring forth quality health care..."*

Consistent with the concept of self-government, recommendations from First Nations are that the funding be provided directly to First Nations to manage health and social programs. A key informant reiterated this:

"I know the government would probably like to see us integrate everything as in the Romanow recommendations, to integrate all funding sources and we administer our own health services...any monies that go to the province through the CHST...it would be nice if we had access to those dollars...we could be working with the province and the feds, but having the direct funding flow to First Nations."

Recent partnerships between the First Nations, provincial and federal governments have seen an approach wherein the provincial and federal governments maintain their funding responsibilities and subsequently the funding levels, with the First Nations at the table providing direction for service in their communities. A recent Memorandum of Understanding (MOU) between the three levels of government for the Island Lake area (Manitoba Health, Health Canada, Island Lake First Nations MOU, 2000) established the basis for negotiations for health services in the Island Lake area. The MOU included a non-derogation clause which stated that the agreement should not be seen by the federal government as able to "alter, diminish, derogate from or prejudice the relationship between ILFN and Canada; or diminish any responsibilities of Canada and Manitoba regarding the delivery of health care to the ILFN according to applicable federal and provincial legislation." (MOU, 2000) A key informant who was a participant in the process indicated that:

"I think that what worked well in this situation was the fact that we established our partnership based upon a memorandum of understanding, where we had all three levels of government – First Nations, federal and provincial governments – all at the table, so that we weren't able to walk away. We had a commitment already at a very high political level to be there and to stay there, and to work towards three particular areas of concern..."

The provincial and federal governments have worked through health transfer initiatives as well, specifically in the communities identified as "1964 Agreement Communities" in northern Manitoba. The Swampy Cree Tribal Council had the majority

of its communities included within the 'provincial' designated areas of the '64 Agreement. In keeping with the principles of health transfer, First Nation communities in the Swampy Cree Tribal Council area approached both the province and the federal government to negotiate health transfer. Discrepancies in the level of service, funding for service, and capital investments in the provincial and federally designated communities created controversy in the initial negotiations. A key informant indicated that:

> *"The province wanted to give us just a little over...dollars to take all the nurses...we felt that wasn't enough...the costs at that time were more than the offer..."*

Processes for resolution and more respectful relationships have now been established for negotiation of these contracts. A tripartite agreement between Canada, Manitoba and the Swampy Cree Tribal Council has been established in 2000 in the "Principles for a Negotiated Agreement", which sets out the terms for service delivery in that area while the three parties are negotiating the termination of the '64 Agreement. There is a willingness to make a commitment to provide a service, and look at what is needed, and then start to look at the financial and jurisdictional responsibility of various levels of government.

The "Non-insured Health Benefits"

In addition to the insured services in a province, the federal government has funded for First Nation peoples, the non-insured health benefits, which include medical transportation for access to health services, dental services, mental health services, prescription drugs and medical supplies and equipment.

First Nations and Inuit Health Branch states that the principles of the NIHB Program are:

- "all registered Indians and recognized Inuit and Innu normally resident in Canada are eligible for non-insured health benefits regardless of location in Canada or income level;
- benefits will be provided based on professional, medical or dental judgement, consistent with the best practices of health services delivery and evidence-based standards of care;
- there will be national consistency of mandatory benefits, equitable access and portability of benefits and services;
- the Program will be managed in a sustainable and cost-effective manner;
- management processes will involve transparency and joint review structures whenever agreed to by First Nations and Inuit organizations; and
- in cases where a benefit is covered under another plan, the NIHB Program will act as the primary facilitator in coordinating payment in order to ensure that the other plan meets its obligations and that clients are not denied service." (FNIHB, Non-Insured Health Benefits Annual Report, 2001/2002, p. 3)

There is some regional variation in the criteria and eligibility for benefits. In Manitoba, for example, off-reserve clients are ineligible for transportation to access health services.

If a client living off-reserve in a northern community requires diagnostic services, specialist consultation or urgent/emergent care in Winnipeg, FNIHB defers this cost to the Northern Patient Transportation Program funded by Manitoba Health (Correspondence, 1998). This would indicate some inconsistency in the application of the principles of the Non-insured Health Benefits Program.

Health care providers have expressed concern about the practice of refusing to approve transportation for patients, despite referral by a professional, such as a physician or dentist. The impression from one key informant is that the decision to approve or refuse medical transportation rests with the Regional office, and often referrals are over-ruled by program decision-makers. There is no clear directive defining eligibility or

criteria for medical travel benefits. Decisions to fund transportation are not necessarily contingent on a professional decision to follow proscribed minimum standards of care. An itinerant health care provider expressed concern about the practice of Regional decision making for transportation to access service outside remote communities:

> *"A lot of people don't even understand that they have a social and public responsibility... When I look at that, I am looking at the transportation services, and it just seems like the clerks there will over-power decisions that have been made by health professionals....It's refused because it could be done at the community level, but the number of days of service that the communities get is inappropriate..."*

This approach to decision-making for benefit eligibility is inconsistent with the principle of professional referral of the NIHB Program as stated in the Annual Report (FNIHB, 2002, p. 3)

Following the formal establishment of organized health services for First Nation peoples on reserve, the implementation of funding the expenditures for the non-insured health benefits occurred. Costs for this service became a concern for the federal government almost immediately. Initially, the costs for these benefits were not capped, and began to accelerate rapidly as both the utilization rates, and the eligible client population base increased (See Appendix 10, Table 1 and Table 2). Throughout the last several decades, Health Canada has made efforts to limit these benefits, always with significant protest from First Nations.

Non-insured Health Benefits – Financial Implications and Utilization Rates

The eligible First Nation client population for non-insured health benefits in Canada rose 9.9% between 1998 and 2002. Manitoba had the largest increase at 11.9% (FNIHB, 2002, p. 8) (Appendix 10, Table 2). Funding for First Nations and Inuit Health Programs includes the NIHB Program Envelope. Other costs within the FNIHB Programs

included community based and hospital based services. The 1995 federal budget set growth levels for the envelope at 3% per annum. The NIHB Program expenditures accounted for more than 40% of all expenditures. (FNIHB, 2002, p. 17)

NIHB annual expenditures have almost doubled in the last decade to a total of $627.8 million in fiscal year 2001/2 (Appendix 10, Table 3). The annual rates of growth, however, have decreased from 20.9% in 1991/2 to 9% in 2001/2. The overall NIHB expenditures growth rate, by region, was second highest in Manitoba (Appendix 10, Table 4 and Table 5). The total cost of non-insured health benefits in Manitoba exceeded $107 million dollars in 2001/2, with greater than $48 million directly attributed to transportation costs to access medical care or diagnostic services (Appendix 10, Table 5). The national per capita expenditures for all benefits totaled $849 in 2001/2 (Appendix 10, Table 6), with Manitoba's per capita expenditure rate at $974 (FNIHB, NIHB Annual Report, 2001/2).

The criteria for eligibility for qualifying for non-insured health benefits for First Nation peoples has not been widely disseminated among the First Nation peoples. There is a lack of consistency in applicability of these criteria and subsequent eligibility for benefits on a regional and national basis. There is a significant variance in the utilization rates of these benefits (Appendix 10, Table 7). The dental benefit utilization ranged from 22% in Manitoba to 48% in Quebec, with an average total utilization rate of 36% overall nationally. The utilization of pharmacy benefits was higher. It ranged from 45% in the NWT and Nunuvut to 78% in Saskatchewan, for an average Canada-wide total utilization rate of 65%. Manitoba's utilization rate for pharmacy benefits was at 68% for 2001/02 (Appendix 10, Table 7).

The total expenditures for pharmacy for all regions, at an average 65% utilization rate topped $252 million dollars (Appendix 10, Table 8), while dental expenditures, at an average rate of 36% totalled over $124 million dollars (Appendix 10, Table 9).

The costs of the non-insured health benefits program continue to escalate as a result of "increasing benefit costs, increased population and utilization, inflation and changes to provincial health care systems". (cited in FNIHB, NIHB Annual Report, 2001/2002, p. 19)

Non-insured Health Benefits – Restraints

Recent efforts by the federal government to implement a consent form, in order to utilize and share the personal information of First Nation peoples has been an additional cause for concern by First Nations. Unlimited access to and utilisation of personal health information, the 'second guessing' by administrative staff of professional decision making, and the potential for further erosion of First Nation health benefits are some of the expressed concerns regarding the initiative.

The process of initiating a consent form for access to personal information for claims processing has been flawed from the outset. Early discussions with the Assembly of First Nations were conducted in 2000. Health Canada proceeded with the development of the process without further consultation with First Nations.

In September of 2002, FNIHB was to begin sharing information with First Nations at the regional levels regarding a proposed consent form to be initiated by Health Canada. An information package was forwarded to Health Canada regional offices for distribution to staff, service providers and clients. Health Canada indicates that the forms are also available at a variety of outlets such as Band Offices, pharmacies, postal outlets,

Friendship Centres, and Nursing Stations or Community Health Centres. (FNIHB, NIHB Consent Form, 2002)

The intent was that all First Nation clients must sign the consent form by September, 2003 in order to maintain eligibility for funding of non-insured health benefits. Strong resistance to the process was expressed by First Nations in Manitoba in November, 2002, at the Assembly of Manitoba Chiefs' Health Conference in Winnipeg.

The consent form allows Health Canada the use of First Nations' personal information. The consent form must be signed by First Nation clients in order to access non-insured health benefits. The federal government has indicated that the consent form is a legal requirement. They have stated that:

> "The consent process will ensure that all eligible clients know what personal information is collected, how the information is obtained, how it is used, who it is shared with, and for what purpose. Given current federal and provincial laws there is a possibility that without the eligible client's consent health providers may refuse to transfer health information for the processing of claims. This may result in eligible clients being denied services or required to pay for their benefits directly." (Health Canada, FNIHB, 2002, p. 103)

Without a signed consent form, FNIHB will not fund the requested benefits. First Nations have expressed concern nationally that the consent form is a form of erosion of the non-insured health benefits program.

Informed consent implies that a full explanation has been given and all potential questions by the client have been answered. In Manitoba, distribution of the consent forms has occurred primarily through retail outlets such as pharmacies and footwear outlets. Boxes of the forms are available for clients to access, and the information on the process has been largely through signage at the outlets and verbally from the pharmacists or other distributors. The consent form includes a section for an interpreter to sign if

language interpretation is required, however, interpreters are not available at the retail outlets to facilitate the process of 'informed consent' on Health Canada's behalf.

The consent form is a 'one time' consent form and gives Health Canada permission for the full use and sharing of all personal information. It states that individuals or organizations accessing client's personal information include:

> "Health Canada or its agents/contractors; claims administrators/ processors; prescribers; health care professionals and their licensing bodies; eligible service providers; First Nations and Inuit organizations under administrative agreements who are providing non-insured health benefits; federal/provincial/territorial insurance plans or third party insurance plans; and Indian and Northern Affairs Canada (only to confirm eligibility)." (Health Canada, NIHB Consent Form, 2002, p. 2)

The consent form allows Health Canada to share personal information with these groups for a variety of reasons. Health Canada states that personal information is used:

> "to confirm eligibility for the program; to process requests and payments to health care providers; to maintain a record of benefits provided to each client, in pharmacy, dental, MS&E audits; for the ongoing review and analysis of claims to ensure benefits reflect: client need, current medical/dental practice, changes in health care delivery (de-listing of services i.e. eye exams), NIHB Program Directives; by a medical or dental consultant and discussed with the client's physician, pharmacist or dentist when prior approval is required; for benefit utilization analysis to identify and better target benefits to clients; for instance, the development of a process for renal dialysis and AIDS patients to access benefits without prior approval; for program planning and evaluation; to inform clients and providers of program changes; to provide statistical information for benefit utilization reviews, such as drug utilization reviews to address misuse and abuse of prescription drugs by sharing information with clients and their physician and pharmacists."(Health Canada, NIHB Consent Form, 2002, p. 7).

The statements in the NIHB Annual Report (2002) indicate that eligible clients will know what information "is collected, how the information is obtained, how it is used, who it is shared with, and for what purpose." (p. 103) Health Canada states that personal information may be disclosed or shared with:

> "provincial or territorial health facilities, Indian and Northern Affairs Canada (INAC), medical insurance plans, and federal, provincial, territorial, or municipal public assistance plans to verify your eligibility under the program and to compile statistics specific to the program." (Health Canada, NIHB Consent Form, 2002, p. 8)

With such broad implications for utilization of the personal information, First Nations have concerns regarding potential future implications for benefit eligibility.

First Nations are in agreement that a consent form for claims processing is necessary. The concept of a blanket consent form that has no time frame, and without clear guidelines or restrictions on the utilization of the data, has implications that are of concern to First Nations. First Nations have been very assertive in recent years as to the need for participatory involvement in any research initiatives involving First Nation information. This form would eliminate all further need for participatory involvement by First Nations in decisions on data utilization and analysis.

The consent form is not voluntary, in the sense that clients are not eligible for benefits if they do not sign. As a result, the consent form process is viewed as a coercive initiative. Medical transportation and prescription drug costs are often prohibitive for individuals. First Nation populations have a high incidence of chronic disease and those individuals affected will require prescription drugs or transportation to access medical care. There is concern from First Nations and from health care providers that individuals will be refused service as a result of this initiative. A discussion with a key informant indicated that:

> *Q: With this consent form process, do you anticipate that there may be gaps in health service... particularly if people do not sign?*
>
> *A: I could see poorer quality of service, a lower quality of service for First Nations. The service providers want to get paid, and they're not going to be very sympathetic to our cause if it's going to affect their*

pocketbooks. And then, some might just throw their hands up in disgust and say: 'why bother if this is the hassle we're going to be getting all the time?' So that's discouraging service providers from giving us the service, I guess.

Q: Are you suggesting that they may refuse to provide the service?

A: Well, they can't. I mean, it's going to force them into a situation where they have to decide 'okay, I can't give this to you because you can't pay.'

Q: Do you think there will be a risk to people's health as a result of this?

A: Some people believe strongly in their Treaty rights and they will put themselves at risk.

Q: So some people will refuse to sign?

A: Yeah. Some people will refuse to sign.

The decision to sign the consent form is a personal choice. It is based on the understanding individuals have regarding the overall process, including the risks and benefits associated with the decision to sign or not sign the form. The potential implications to clients who cannot afford to pay for these benefits, health care providers who have a need to adhere to standards of care from an ethical perspective, and the financial implications to the province, are to be considered. One key informant who provides service as a health care provider expresses concern:

"I worry that I will see patients who will need a cane, will need a walker, will need medications because the disease burden is so high, and if they're not on welfare...they may not get adequate supplies and things. So there will be a lot of work to try and ensure that people get the care and treatments that they need...most of the people I see are poor. A lot of them are illiterate. A lot of them need to get food, have a safe place to be, and have proper housing. They're not worried abut filling out forms for two or three hours in order to get $100 or $150 back from the thing. It's frightening to think that that could happen...I worry that people will not get treatment as a result."

There are potential implications for First Nation patients who do not have sufficient funds to pay for benefits are concerning. There are also potential implications for provincial health and social services systems that may be viewed as a default for funding these services in the event that individuals do not sign the form. One health care provider indicated concern:

> *"The current thing that's a real big issue in my mind is whether or not the non-insured health benefits are jeopardized by what the federal government wants to do with the consent form...How can the province respond to that positively, or how can other governments respond positively to ensure that those benefits are maintained?"*

The financial situation of each FNIHB region, and the provincial health system appears to play a role in the consistency and delivery of these health services.

Medical transportation is a benefit under the NIHB Program, and has been a rapidly escalating expenditure for First Nations and Inuit Health Branch, particularly in Manitoba. Cost drivers for this benefit include escalating costs of air travel, increased burden of illness requiring access to medical services, and increased utilization of services. Manitoba established the Northern Patient Transportation Program in order to facilitate access to medical care for northern patients requiring health care in Winnipeg. Air travel costs were often beyond capacity of patients to manage and this program ensured that patients were able to travel to receive the care they needed.

FNIHB (then Medical Services Branch) had traditionally paid retroactively to Manitoba Health, the accumulated costs of off-reserve patients. In an effort to contain costs in Manitoba region in 1998, the then Regional Director for FNIHB corresponded with the ADM for Health Programs of Manitoba Health and indicated that FNIHB would no longer fund transportation for off-reserve clients in the province (FNIHB

correspondence, to Manitoba Health Assistant Deputy Minister, April, 1998). This unilateral decision had negative implications for the Manitoba government at that time as budgets for the year had already been set, no negotiation had occurred, and the move was not anticipated. FNIHB re-affirmed their commitment for ground ambulance in city, accommodations and meals for those individuals.

Correspondence from the Assistant Deputy Minister ("ADM") for FNIHB, in October of 1997 established the guidelines for a renewed mandate in NIHB. The provisions included:

- continued eligibility for all registered Indians regardless of location;
- program principles that build on the 1979 Indian Health Policy to meet the health needs of clients whose health status lags behind that of other Canadians; and
- the establishment of mandatory benefits for all clients on or off reserve.

There would appear to have been a change in thinking, yet again, about the need for a renewed mandate for non-insured health benefits. This recent change in eligibility for coverage is, however, consistent with the historical efforts to limit access to non-insured health benefits for First Nation peoples.

A recent meeting with the federal Minister of Health, and the Assembly of First Nations Grand Chief resulted in a postponement of the deadline for consent forms for the NIHB program. Discussions are ongoing in an effort to establish a process that is agreeable to both parties.

The administration and management of the NIHB Program at the federal level is reflective of issues that arise as a result of jurisdictional ambiguity. There is potential for gaps in service and barriers to service for First Nation peoples. There are risks to the

health of First Nation peoples secondary to a reduced access to needed services if clients are not eligible for benefits. As a result of the process that excluded First Nations, significant time delays have occurred in the implementation of acceptable management guidelines for the NIHB Program. This has further eroded the relationship between the federal government and the First Nations.

4.3 RATIONALE AND STRATEGIES FOR RESOLUTION OF JURISDICTIONAL ISSUES

The role of the researcher is not to offer suggestions or proposals of comprehensive solutions to identified issues. The conclusions stated are reflective of key informant statements or suggestions, and summaries of the policy documents reviewed.

4.3.1 Rationale

Government does not have a good track record when entering into respectful partnerships with First Nation governments. There is a lack of trust as to the real intentions behind the government agendas for resolution of First Nation issues on jurisdiction. This ambiguity has allowed government to avoid policy agendas that would benefit from the resolution of outstanding issues related to jurisdiction. A health care administrator noted that:

> *"I'm not sure that there's any particular interest in resolving it...I think the federal government has tried to withdraw from service, so they don't really care, because they're leaving. The provincial government just sees it as another cost center. And Aboriginal people aren't sure who they want more in the communities – the feds or the province – because it's not clear what benefit either of them brings."*

The need for collaborative approaches to resolving outstanding jurisdictional issues has been established. In all of the areas of public health, primary health care, social services, and education services, there is room for partnership development in order to begin to address the social determinants affecting the health status of First Nation peoples.

The unanimous conclusion of all key informants was that efforts must be made to strategize on collaborative means of integrating services. Although key informants do acknowledge that trust is an issue, there is a political will by the interested parties in

focusing on the potential strategies for resolution. One key informant who is an administrator with the federal government stated:

> *"I'm not sure that the right levels of trust are in place yet. I think we're seeing some clear signals in terms of political will to want to move towards some integration. I think that in order for integration to work properly, we actually have to do something that we have not done particularly well, and that's really meaningfully consult with First Nations about what this means, about how we intend to do things, and to relay any concerns that almost inevitably emerge when we have these conversations around somebody trying to escape their responsibilities....you also want to look for examples where you're doing it successfully now, because that speaks more loudly to the issue of trust than anything else."*

One provincial administrator had indicated that:

> *"...ideally what we need to create in Manitoba is a tripartite process that says, let's bring to the table leaders of First Nations communities, the federal government and the province, and let's see if we can establish some principles of working together in an integrated system that brings us more towards integration than separation of roles and responsibilities..."*

First Nations have echoed this sentiment but have reiterated the need for equitable partnerships based on recognition of the right to self-government. A key informant commented that:

> *"I think that as a political organization, the Assembly should be spearheading the push towards recognition of our participation. We should be meeting with the minister of health federally, provincially...when they have the first ministers conferences, they give one seat to the AFN...I think there should be one First Nations person from each province, much like their own first ministers...they need to begin to recognize the regions...We've made some recommendations to the minister of health here in the province, saying that we want First Nations participation at the event on health."*

4.3.2 Strategies

First Nation policy makers have indicated that efforts are underway to work together to look at the recommendations of the Romanow Commission. An informant commented on the process to date:

"Politically and operationally, we've had the minister of health, minister of Health Canada, and First Nations organizations in Manitoba – SCO, MKO and AMC sign on the fact that we worked together to try to look at Aboriginal health issues as per Romanow. We're using Romanow as a starting point to that."

The establishment of a sustainable health services system based on peoples needs requires the "active contribution of key stakeholders, or health partners" (Boelen, World Health Organization, 2000). The five principal partners identified by the World Health Organization (WHO) include policy-makers, health managers, health professionals, academic institutions and communities. The members of this "partnership pentagon" will share a common set of values such as quality, equity, relevance and cost effectiveness and will also share a common vision for future health services delivery. A key informant shared their vision for maximizing services:

"I saw the provincial system itself has a lot of experience in providing these kinds of services...I really believe the First Nations communities, with the federal government and the province have to collaborate on how to share resources and how to share information and skills, and transfer skills back and forth, cultural skills from the First Nations to the non-indigenous peoples and usable medical skills, nursing skills to the First Nations...it's important that those three governments again look at how to train First Nations people to deliver those skills...It has to become part of the solution."

A health care provider commented on potential strategies for addressing jurisdiction, and ultimately, health status of First Nations:

"...the definition between the federal government and First Nations has to be much more clearly defined and the implicit has to become explicit...once that's done, I think First Nations people will have a better idea of how they communicate with the province without having fear of losing their relationship with the federal government...my perception actually with the provincial government is that despite the provincial government not wanting to go on-reserve to provide some services, I think they, seemingly in my mind, they seem a little bit more apt to want to become involved at different levels with First Nations health."

A First Nations policy maker defined some key steps in the process for developing strategies for health:

> *"...I think the political organizations, like the Assembly of Manitoba Chiefs, have to become involved with the federal Crown through FNIHB here at the region, and then we have to become involved with the minister of health in this province in terms of defining our own responsibilities and jurisdictions...the leadership will determine the level of participation in terms of the different decision-making areas."*

Only through an established partnership process will there begin the means to address the disparities in health status. Partners must have an active and equitable role in the development, implementation and evaluation of health services for First Nation peoples.

CHAPTER 5

SUMMARY OF FINDINGS AND CONCLUSIONS

There are numerous situations and case studies wherein jurisdictional issues have had primarily negative effects on our ability to provide comprehensive and culturally relevant heath care services for First Nation peoples. This study has documented some of these situations through the observations and experiences of key informants. The case studies illustrate real situations and events that have negatively influenced health service delivery and access to service for First Nations. In addition, the case studies have identified some areas wherein there are potentially serious risks to the health of First Nations and all Canadians.

5.1 SUMMARY OF FINDINGS

The need for resolution of issues of jurisdiction has been well established. A review of policy documents has documented the basis for inequities in service delivery in the health and social sectors. A review of the summaries of numerous forums, commissions and round tables have further confirmed these findings. Key informant interviews have illustrated actual situations wherein jurisdictional ambiguity has had a direct impact on the health service and health outcomes.

Jurisdictional ambiguity has resulted from the historically entrenched perceptions of First Nation peoples and perceptions of their rights in Canada. A lack of meaningful commitment to the resolution of issues of jurisdictional responsibility for First Nation peoples health and social services is evident in the lack of response to the recurrent recommendations of nationally conducted Commissions. Minimal activity has occurred following the recommendations of the Royal Commission on Aboriginal Peoples, and more recently, Canadians at large have expressed concern on the lack of action following the Romanow Report.

This inactivity has negatively affected national perspectives on the legal, moral and ethical obligations of the federal government to First Nations. Jurisdictional disputes between federal and provincial governments have sustained the situations that result in disproportionate levels of social inequities for First Nation peoples. First Nations governments have been excluded from discussions that may have resulted in meaningful dialogue for resolutions to these inequities. The disparities in health status between First Nation peoples and all other Canadians remain unacceptably high.

5.1.1 Jurisdictional Ambiguity

The framework for health services (Figure 1) illustrates the inter-connectedness of the political funding organizations, and the overlapping boundaries of the regional health authorities and First Nation communities where the actual service delivery occurs. This study has focused on identifying the need for strategic remediation of the factors that negatively affect the health status of First Nation peoples, and risks to the health of First Nations.

Case studies shared by key informants have identified key areas of concern, which are impacted by ongoing jurisdictional ambiguity. These include the need for positive approaches in addressing the effects of colonialism, the need to acknowledge First Nations rights, and a collaborative approach to integrated services for First Nation peoples.

5.1.2 Colonialism and the Historical Perceptions of Aboriginal Peoples

The historical validation by government that First Nation peoples are a population who are not valued by Canada has been described as 'ethnocide' and 'genocide' and has been the basis for international appeals for restitution. Enforcement of the explicit and implicit policies of assimilation has resulted in generations of First Nation peoples who have struggled to establish their rights as the First Peoples of this country.

Ambiguity in decision making on First Nation issues is reflective of the continued "political, social and economic censure" (Postl, 1995, p. 91) of First Nation peoples. This jurisdictional ambiguity serves to validate the national perceptions of a people who are not recognized as people with special status because they are not entitled to this recognition. The reluctance of the federal government to establish precedents for fair and

equitable treatment of First Nations in the realm of political and social responsibility is unacceptable and fosters continued inequities.

Policy document review has established the need for a commitment to the resolution of jurisdictional ambiguity. The federal government must acknowledge the results of colonialism on First Nations and work with First Nations to establish a process for reversing these perceptions and to address the affects on First Nation peoples. Advocacy for First Nation peoples, by First Nation peoples, must be strongly supported by the partners who are committed to effecting change. Clarity on the roles and responsibilities of the federal government to the First Nations must be established. A commitment to the process would be established by a declaration of the expected responsibilities of the federal and provincial governments.

5.1.3 Aboriginal (First Nation) Rights

The historical challenges encountered by the First Nation peoples in asserting their inherent rights as the First Peoples of Canada are well documented. Persistent efforts by First Nations to gain the federal governments commitment for the entrenchment of the inherent rights of First Nations must be acknowledged. A process for the fair and equitable definition of these rights must be determined.

Decisions made by the federal government have been dependant on the personal beliefs of the individuals in power at any given time. Leaders have made public statements of reaffirmation of the legislation while concurrently drafting policies that will continue the enforcement of assimilation. The lack of trust, and mistrust afforded the federal government by First Nations is not without justification. Halfway measures by government which are intended to pacify First Nations, while a predetermined course of

action proceeds, has been the norm in relationships between the federal government and First Nations.

The devastation to the First Nations population by the unilateral and ill-considered decisions of assimilation, while ignoring the rights of First Nations by the federal government must be acknowledged. Some positive initiatives have occurred through acknowledgement of the effects of the residential school process and the establishment of the Healing Foundation. Documenting the need for change, and making efforts to implement change in the judicial system, are viewed as positive. Changes to the management of the education system and to the education curriculum, and the move to First Nations management of health programs through health transfer are also positive initiatives. In all instances, the consultation and collaboration with First Nations has been the key component in determining the success of these initiatives.

5.1.4 Access to Service

The effects of the negative attitudes and behaviours toward First Nation peoples that have resulted from the historical perspectives of Canadians must be acknowledged. The gaps in service, the barriers to service, and ultimately, the risks to health for First Nation peoples will not be resolved or addressed without this initial effort. Established policies and protocols, which are clearly defined, must be affected. Without these efforts, resolution of jurisdictional ambiguity will not occur.

The level of health service programs delivery for First Nations on reserve lags behind that of other Canadians for a variety of reasons. Key informants have shared case studies indicating that the ability of First Nations to access service off-reserve is often hampered by the perceptions of service providers that a parallel system exists for First

Nations. Jurisdictional ambiguity and degree of responsibility is clearly a factor. The fiscal responsibility associated is frequently the determining factor in decisions to provide or refuse service in health or social services. The complexity of service provision across jurisdictions for First Nation peoples is frequently a decisive issue when individual health care providers must make a decision as to whether or not the program or service is accessible to First Nation peoples.

Access to service that meets the needs of First Nation peoples must be equitably delivered on- and off- reserve. Covert policies for limiting access to service for First Nations through individual decisions, or program specific decision making, is not acceptable.

Key informants have identified the need for clarity on the scope of jurisdictional responsibility in program delivery for on- and off- reserve First Nation peoples. Jurisdictional responsibility of both the federal and provincial government as they relate to the First Nations must be clarified. Dissemination of those defined areas of responsibility must be decided with the collaboration of First Nations, and then shared with First Nations and with all federal and provincial government departments and personnel.

Without clarity on jurisdiction, the ability of First Nations to negotiate for the authority to manage services for their communities is hampered by the subjective interpretations of individuals acting on behalf of government. Only with clarity on jurisdiction will there by clarity on the parameters for First Nations autonomy in health and social services management.

5.1.5 Jurisdictional Responsibility

Key informants' sharing of situations and case studies identified a need for acknowledgement of jurisdictional responsibility in specific areas. Jurisdictional ambiguity has resulted in barriers to service and potential risks to health. Key informants expressed concern that the need for fiscal restraint has further impacted decisions that would involve assuming the financial responsibility for health and social services.

5.1.6 Barriers to Service

Key informants have illustrated that the risks to health are not limited to First Nation peoples alone if jurisdictional ambiguity is not resolved. There is a need for clarity in jurisdictional responsibility in public health and environmental health program delivery. There are very real risks to health of First Nations and all Canadians with the existing gaps in the system. Emerging global diseases alone are reason enough for a shift in attitudes toward what might constitute an integrated approach to service delivery.

There are existing and potential barriers to service delivery in primary health care and in support services as a result of the lack of commitment by the federal or provincial governments for services on reserve, or for First Nation peoples living off reserve. Key informants have indicated that there are concerns about the potential barriers to service, gaps in service, and ultimately, risks to health if jurisdictional issues are not satisfactorily resolved. The federal, provincial and First Nations governments must establish a process for collaborative resolution of outstanding issues in jurisdiction for health and social services programming. Integrated service initiatives between governments and government departments are critical to ensuring a comprehensive approach that addresses emerging issues.

Key informants have indicated that the federal and provincial governments must work in meaningful relationships with First Nations to establish the scope of health and social services programming and related benefits. Initiatives of the federal government, such as the consent form for funding on non-insured health benefits, have potential risks for a decrease in the present service levels for First Nations. Unilateral decisions by government for service withdrawal and service reduction as a means of fiscal restraint will result in prohibitive costs to First Nations health status.

5.1.7 Financial Responsibility

The burden of illness in the Aboriginal and First Nation populations ultimately results in significant financial costs for health care services delivery. Clarity on the process for provision of service to First Nations, under both the provincially funded insured health services and the federally funded non-insured health benefits must be established.

Efforts to contain costs in health service delivery have become an expectation of governments when establishing the funding base for health and social programs. A need for balance between cost effective health services and quality health care is a critical component of health services planning. The disparities in health status for First Nations as compared to all Canadians are acknowledged as a need for focused efforts to address the determinants of health that can effect a change in health status.

The escalating costs of health services has resulted in high expenditures for acute care services and limits governments' ability to shift funds to health promotion and social programming efforts that could make a difference over time on the health status of a population. First Nations have maintained that there is a need for community specific

programming that addresses the health and social needs of their communities. The need for comprehensive support services at the community level is important in the evolution from a hospital based health system, to a system where community based services provide most support and convalescence services. Changes that will affect community-based programs must be done through a tri-partite process, following consultation and consensus building between the decision makers, providers and First Nation clients.

Erosion of non-insured health benefits will further impact the health status of First Nation peoples. Individuals require medical transportation to access health services, funded benefits for prescription drugs and access to medical supplies and equipment that will support their independence at the community level. A comprehensive approach to health care and health program planning that is inclusive of systems that support health and social services is necessary to improve the health status of First Nation peoples.

5.2 CONCLUSIONS

5.2.1 Significance of the Study

The findings of this study have implications for First Nations – both at the political planning level and at the service delivery level for individual groups. First Nation peoples can use the study to assist in assessing the relevance of historical policy and service issues, and to anticipate future initiatives based on the analysis of the health care providers conclusions of key issues.

Recognition of the consensus on key issues in health care for First Nations is an important note. A commitment to a process for the resolution of historical inactivity is evident in the analysis of data from this group. Ongoing health and social policy reform, which is based to some degree on fiscal responsibility, is a key component in the future decision making for programming for First Nation peoples. The need to address disparities in health and social status of First Nation peoples has been identified as a priority.

This project reflects the need for consensus building and equitable partnerships in health care planning. Cost effective programs can be sustainable, and if these programs are delivered in a cultural context that is relevant to First Nation peoples, then the foundation for collaborative governance and administration of these programs will have credibility in all sectors.

5.2.2 Conclusions

The Royal Commission on Aboriginal Peoples identified numerous strategies regarding indigenous peoples health (RCAP, 1996). Guidelines for action in health included equity, holism, recognition of diversity, and the need for Aboriginal control over

health systems. Strategies for the restoration of community health were identified as the need for Aboriginal healing centres, the development of Aboriginal human resources, the full and active support of mainstream health and social services in meeting the needs and goals of Aboriginal peoples, and the implementation of an Aboriginal community infrastructure development program to address the most immediate health threats (RCAP, 1996).

Governments' reluctance to fully implement the recommendations of the RCAP is an example of jurisdictional ambiguity. The financial costs of the consultation process for the development of the RCAP were significant, and implied a real commitment to the process of change in the relationship between government and the Aboriginal people. The delays encountered have been disappointing.

The negative effects of jurisdictional ambiguity on the health status of First Nation peoples are documented in the perceptions and observations of key informants in this study. There is a need for more of the collaborative efforts such as those that have been identified in Manitoba. These efforts have been established as a means of restoring autonomy and gaining meaningful ways of establishing priorities in health services planning for First Nation communities.

Forward action on these guidelines and strategies must be tackled by collaborative partnerships between all levels of government, and government departments, with meaningful involvement by the community. Responsibility must be assumed by all levels of government, and assurance of appropriate resources and infrastructure development must accompany a sustainable commitment for relevant program development and implementation.

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APPENDIX 1

1964 AGREEMENT BETWEEN HEALTH CANADA AND PROVINCE OF MANITOBA

'64 Agreement

MEMORANDUM OF AGREEMENT BETWEEN THE DEPARTMENT OF NATIONAL HEALTH AND WELFARE, as represented by the Medical Services Directorate, AND THE DEPARTMENT OF HEALTH OF TH PROVINCE OF MANITOBA, as represented by the Division of Health Services.

It is agreed that in the following areas: Moose Lake, Grand Rapids, and Cedar Lake to the southeast of The Pas, and in the Bay Line communities of Cormorant, Wabowden, Spipwosk, Thicket Portage, Pikwitonsi, Ilford, Gillam, and Bird, together with and including all section houses on the C. N. Railway Line as far north as Churchill, the Local Government District of Churchill and the Local Government District of Lynn Lake, the Provincial Northern Health Services would provide clinical and public health services in the field.

In the following areas: Nelson House, Pukatawagan, South Indian Lake, Brochet, Split Lake, York Landing, Shamattawa, The Pas Reserve, Norway House, Cross Lake, Oxford House, God's Lake, Island Lake, Ste. Theresa Point, and Granville Lake, Medical Services of the Department of National Health and Welfare would provide clinical and public health services in the field.

In addition, it is further agreed that the individual services would supply professional and ancillary personnel to the above areas, and be responsible for their own drugs and medical supplies, although Medical Services agreed that they would continue to supply durgs to Provincial Northern Health Services at cost plus ten per cent.

The respective services would undertake fiscal responsibility for transport of staff and patients for whom they are responsible. In the case of Provincial Northern Health Services, this would apply to Non-Indian patients, and in the case of Medical Services, Department of National Health and Welfare, this would apply to Indian patients only. Each service, however, will accept fiscal responsibility for such arrangements made by the other service for a patient on behalf of the first service. For example, Medical Services will accept financial responsibility for Indian Patients moved from Moose Lake to The Pas by Provincial Northern Health Services without prior authorization. Provincial Northern Health Services will accept financial responsibility for movement of all indigent Non-Indian patients in communities served by Medical Services, Department of National Health and Welfare without prior authorization. Except in cases of emergency, it is agreed that consultation between the two services should be made whenever possible, on all movement of patients prior to such movement.

Venereal disease control shall remain under the Provincial Northern Health Services jurisdiction, but in the field, staff of the individual services would be responsible for location of contacts, advisory services, etc.

In the field of tuberculosis control, each service shall be responsible for its program within its own area, but there shall be a mutual interchange of information and data.

Each service will be responsible for the establishment and maintenance of communications to effect the movement of patients to and from hospital. That is, in the areas of responsibility as outlined above, Medical Services, Department of National Health and Welfare will be responsible for the necessary arrangements required to transport all patients from their communities to hospital or clinic, together with information pertaining to the patient being moved. Likewise, Provincial Northern Health Services will be responsible for identical arrangements regarding transportation of all patients in their area of operation.

Provincial Northern Health Services will undertake to provide supervision of environmental sanitation where feasible, if and when requested by Medical Services, Department of National Health and Welfare, in areas of their jurisdiction.

Zone Superintendent, Medical Services, at Norway House, will be named Deputy Health Officer to the Director of Northern Health Services, and be responsible for administration of The Public Health Act in the area of his jurisdiction, under the direction of the Director of Northern Health Services.

With regard to Lynn Lake Nursing Station it is desired that Non-Indian and Inuit medical referrals be boarded elsewhere. It is agreed that with respect to the operation of Lynn Lake Nursing Station, that the Provincial Northern Health Services will base one public health nurse at this station to:

1. Provide public health services to the Lynn Lake community.
2. Make arrangements for non-Indian medical referrals.
3. Assist in the operation of the Nursing Station when both nurses are in Lynn Lake.
4. In the absence of a Medical Services field nurse, the Northern Health Services nurse will operate Lynn Lake Nursing Station, make arrangements for Indian medical referrals, and make emergency trips to outlying areas for Medical Services.

Medical Services in turn will be responsbile for the operation of Lynn Nursing Station. The Medical Services field Nurse's duties will include:

1. Nurse in charge of Lynn Lake Nursing Station.
2. Provide public health services and minor treatment services in her area of responsibility - Brochet, South Indian Lake and environe.
3. Make arrangements for Indian medical referrals.
4. In the absence of a Provincial Northern Health Services nurse, the Medical Services nurse will also make arrangements for non-Indian referrals and make emergency trips for Provincial Northern Health upon request.
5. Assist Provincial Northern Health Services Nurse in emergencies and in large public health programs, i.e. mass immunization of the community, or upon request from Provincial Northern Health Services through The Pas Zone Superintendent.

This Agreement is to be effective on the 1st day of April, 1964.

(original signed by P. E. Moor

On Behalf of Medical Services D
DEPARTMENT OF NATIONAL HEALTH A

On Behalf of the Division of He
DEPARTMENT OF HEALTH, PROVINCE

APPENDIX 2

ROYAL PROCLAMATION of 1763 (excerpt)

And whereas it is just and reasonable, and essential to our Interests, and the Security of our Colonies, that the several Nations or Tribes of Indians with whom We are connected, and who live under our Protection, should not be molested or disturbed in the Possession of such Parts of our Dominions and Territories as not having been ceded to or purchased by Us, are reserved to them, or any of them as their Hunting Grounds. –We do therefore, with the Advice of our Privy Council, declare it to be our Royal Will and Pleasure, that no Governor or Commander in Chief in any of our Colonies of Quebec, East Florida, or West Florida, do presume, upon any Pretence whatever, to grant Warrants of Survey, or pass any Patents for Lands beyond the Bounds of their respective Governments, as described in their Commissions; as also that no Governor or Commander in Chief in any of our other Colonies or Plantations in America do presume for the present, and until our further Pleasure be known, to grant Warrants of Survey, or pass Patents for any Lands beyond the Heads of Sources of any of the Rivers which fall into the Atlanti Ocean from the West and North West, or upon any lands whatever, which, not having been ceded to or purchased by Us as aforesaid, are reserved to the said Indians, or any of them.

And We do further declare it to be Our Royal Will and Pleasure, for the present as aforesaid, to reserve under our Sovereignty, Protection and Dominion, for the use of the said Indians, all the Lands and Territories not included within the Limits of Our said Three new Governments of within the Limits of the Territory granted to the Hudson's Bay Company, as also all the Lands and Territories lying to the Westward of the Sources of the Rivers which fall into the Sea from the West and North West as Aforesaid.

And We do hereby strictly forbid, on Pain of our Displeasure, all our loving Subjects from making any Purchases or Settlements whatever, or taking Possession of any of the Lands above reserved, without especial leave and Licence for that purpose first obtained.

And We do Further strictly enjoin and require all Persons whatever who have either wilfully or inadvertently seated themselves upon any Lands within the Countries above described, or upon any other Lands which, not having been ceded to or purchased by Us, are still reserved to the said Indians as aforesaid, forthwith to remove themselves from such settlements.

And whereas great Frauds and Abuses have been committed in purchasing Lands of the Indians to the great Prejudice of our Interests and to the great Dissatisfaction of the said Indians; in order therefore to prevent such Irregularities for the future, and to the end that the Indians may be convinced of our Justice and determined Resolution to remove all reasonable Cause of Discontent, We do, with the Advice of our Privy Council, strictly enjoin and require, that no private Person do presume to make any Purchase from the said

Indians of any Lands reserved to the said Indians, within those parts of our Colonies where We have thought proper to allow Settlement; but that if at any Time any of the said Indians should be inclined to dispose of the said Lands, the same shall be purchased only for Us in our Name, at some public Meeting or Assembly of the said Indians, to be held for that Purpose by the Governor or Commander in Chief of our Colony respectively within which they shall lie; and in case they shall lie within the limits of any Proprietary Government, they shall be purchased only for the Use and in the name of such Proprietaries, conformable to such Directions and Instructions as we or they shall think proper to give for that Purpose; and we do, by the Advice of our Privy Council, declare and enjoin that the Trade with the said Indians shall be free and open to all other Subjects whatever, provided that every Person who may incline to Trade with the said Indians do take out a Licence for carrying on such Trade from the Governor or the Commander in Chief of any of Our Colonies respectively where such Person shall reside, and also give Security to observe such Regulations as We shall at any Time think fit, by ourselves or by our Commissaries to be appointed for this Purpose, to direct and appoint for the Benefit of the said Trade.

And we do hereby authorize, enjoin, and require the Governors and Commanders in Chief of all our Colonies respectively, as ell those under Our immediate Government as thoe under the Government and Direction of Proprietaries, to grant such Licences without Fee or Reward, taking especial Care to insert therein a Condition, that such Licence shall be void, and the Security forfeited in case the Person to whom the same is granted shall refuse or neglect to observe such Regulations as We shall think proper to prescribe as aforesaid.

And we do further expressly enjoin and require all Officers whatever, as well Military as those Employed in the Management and Direction of Indian Affairs, within the Territories reserved as aforesaid for the use of the said Indians, to seize and apprehend all Persons whatever, who standing charged with Treason, Misprisions of Treason, Murders, or other Felonies or Misdemeanours, shall fly from Justice and take Refuge in the said Territory, and to send them under a proper guard to the Colony where the Crime was committed of which they stand accused, in order to take their Trial for the same.

Given at our Court of St James', the 7th Day of October, 1763, in the Third Year of our Reign.

GOD SAVE THE KING

APPENDIX 3

CONSTITUTION ACT 1867
Sections 91 and 92

Section 91 reads:

91. It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make laws for the Peace, Order, and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces; and for greater Certainty, but not so as to restrict the Generality of the foregoing Terms of this Section, it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,

1. Repealed.

1A. The Public Debt and Property.

2. The Regulation of Trade and Commerce.

2A. Unemployment insurance

3. The raising of Money by any Mode or System of Taxation.

4. The borrowing of Money on the Public Credit.

5. Postal Service

6. The Census and Statistics.

7. Militia, Military and Naval Service, and Defence.

8. The fixing of and providing for the Salaries and Allowances of Civil and other officers of the Government of Canada.

9. Beacons.

10. Navigation and Shipping.

11. Quarantine and the Establishment and Maintenance of Marine Hospitals.

12. Sea Coast and Inland Fisheries.

13. Ferries between a Province and any British or Foreign Country or between Two Provinces.

14. Currency and Coinage.

15. Banking, Incorporation of Banks, and the Issue of Paper Money.

16. Savings Banks.

17. Weights and Measures.

18. Bills of Exchange and Promissory Notes.

19. Interest.

20. Legal Tender.

21. Bankruptcy and Insolvency.

22. Patents of Invention and Discovery.

23. Copyrights.

24. Indians, and Lands reserved for the Indians.

25. Naturalization and Aliens.

26. Marriage and Divorce.

27. The Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters.

28. The Establishment, Maintenance, and management of Penitentiries.

29. Such Classes of Subjects as are expressly excepted in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislature of the Provinces.

And any Matter coming within any of the Classes of Subjects enumerated in this Section shall not be deemed to come within the Class of Matters of a local or private Nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

Section 92 reads:

92. In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,

1. Repealed.

2. Direct Taxation within the Province in order to the raising of a Revenue for Provincial Purposes.

3. The borrowing of Money on the sole Credit of the Province.

4. The Establishment and Tenure of Provincial Offices and the Appointment and payment of Provincial Officers.

5. The Management and Sale of the Public Lands belonging to the Province and of the Timber and Wood thereon.

6. The Establishment, Maintenance, and Management of Public and Reformatory Prisons in and for the Province.

7. The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

8. Municipal Institutions in the Province.

9. Shop, Saloon, Tavern, Auctioneer, and other Licences in order to the raising of a Revenue for Provincial, Local, or Municipal Purposes.

10. Local Works and Undertakings other than such as are of the following Classes:

    (a) Lines of Steam or other Ships, Railways, Canals, Telegraphs, and other Works and Undertakings connecting the Province with any other or others of the Provinces, or extending beyond the Limits of the Province;

    (b) Lines of Steam Ships between the Province and any British or Foreign Country;

    (c) Such Works as, although wholly situate within the Province, are before or after their Execution declared by the Parliament of Canada to be fore the general Advantage of Canada or for the Advantage of Two or more of the Provinces.

11. The Incorporation of Companies with Provincial Objects.

12. The Solemnization of Marriage in the Province.

13. Property and Civil Rights in the Province.

14. The Administration of Justice in the Province, including the Constitution, Maintenance, and Organization of Provincial Courts, both of Civil and of Criminal Jurisdiction, and including Procedure in Civil Matters in those Courts.

15. The Imposition of Punishment by Fine, Penalty, or Imprisonment for enforcing any Law of the Province made in relation to any matter coming with any of the Classes of Subjects enumerated in this Section.

16. Generally all Matters of a merely local or private Nature in the Province.

APPENDIX 4

TREATY 6

THE TREATIES OF CANADA

WITH

THE INDIANS OF MANITOBA

AND

THE NORTH-WEST TERRITORIES,

INCLUDING

THE NEGOTIATIONS ON WHICH THEY WERE BASED, AND OTHER INFORMATION RELATING THERETO.

BY

THE HON. ALEXANDER MORRIS, P.C.,

LATE LIEUTENANT-GOVERNOR OF MANITOBA, THE NORTH-WEST TERRITORIES, AND KEE-WA-TIN.

TORONTO:

BELFORDS, CLARKE & CO., PUBLISHERS.

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TO HIS EXCELLENCY

The Right Honorable the Earl of Dufferin,

Her Britannic Majesty's Ambassador at St. Petersburg, K.P.P.C., K.C.B., G.C.M.G., &c., &c., &c.

MY LORD,—

Encouraged by the earnest interest, your Lordship ever evinced, in the work of obtaining the alliance and promoting the welfare of the Indian tribes in the North-West of Canada, and in opening up the Territories for settlement, by obtaining the relinquishment of the natural title of the Indians to the lands of the Fertile Belt on fair and just terms, I have the honor, by your kind permission, to dedicate this collection of the treaties made with them, to your Excellency, in the belief that its publication will be timely, and that the information now supplied in a compact form, may prove of service to the Dominion of Canada.

I have the honor to be

Your Lordship's obedient servant,

ALEXANDER MORRIS,

Late Lieut.-Gov. of Manitoba, the North-West Territories, and Kee-wa-tin.

TORONTO, *March, 1880.*

Signed by the parties in the presence of the undersigned witnesses, the same having been first explained to the Indians by the Honorable James McKay:

(Signed) THOMAS HOWARD.
RODERICK ROSS.
E. C. MORRIS.
A. G. JACKES, M.D.
ALEXANDER MATHESON.
JOSEPH HOUSTON.
CHRISTINE V. K. MORRIS.

Memorandum.

The Queen's Indian Commissioners having met Thickfoot and a portion of the Islands band of Indians at Wapang or Dog Head Island, on the twenty-eighth day of September, A.D. 1875, request him to notify the Island Indians and those of Jack Head Point, to meet at Wapang an Indian agent next summer, to receive payments under the treaty which they have made with the Indians of Norway House, Berens River, Grand Rapids and Lake Winnipeg, and in which they are included, at a time of which they will be notified, and to be prepared then to designate their Chief and two Councillors. The Commissioners have agreed to give some of the Norway House Indians a reserve at Fisher Creek, and they will give land to the Island Indians at the same place.

Given at Wapang, this 28th day of September, A.D. 1875, under our hands.

ALEXANDER MORRIS,
Lieut.-Governor.
JAMES MCKAY.

I accept payments under the treaty for myself and those who may adhere to me, and accept the same and all its provisions, as a principal Indian, and agree to notify the Indians as above written.

Wapang, September 28th, 1875.

(Signed) THICKFOOT. His x mark.

Witness:
(Signed) THOMAS HOWARD.
RODERICK ROSS.

NOTE.—In 1876 Messrs. Howard and Reid obtained the adhesions to the Winnipeg Treaty of the Indians of the Dog Head, Bloodvein River, Big Island, and Jack Fish Head bands on Lake Winnipeg, and of the Island and Grand Rapids of the Berens River band, and of the Pas, Cumberland and Moose Lake bands on the Saskatchewan River, as will be found stated in Chapter VIII.

THE TREATIES AT FORTS CARLTON AND PITT, NUMBER SIX.

ARTICLES OF A TREATY made and concluded near Carlton, on the twenty-third day of August, and on the twenty-eighth day of said month, respectively, and near Fort Pitt on the ninth day of September, in the year of Our Lord one thousand eight hundred and seventy-six, between Her Most Gracious Majesty the Queen of Great Britain and Ireland, by her Commissioners, the Honorable Alexander Morris, Lieutenant-Governor of the Province of Manitoba and the North-West Territories, and the Honorable James McKay and the Honorable William Joseph Christie, of the one part, and the Plain and the Wood Cree Tribes of Indians, and the other Tribes of Indians, inhabitants of the country within the limits hereinafter defined and described, by their Chiefs, chosen and named as hereinafter mentioned, of the other part.

Whereas the Indians inhabiting the said country have, pursuant to an appointment made by the said Commissioners, been convened at meetings at Fort Carlton, Fort Pitt and Battle River, to deliberate upon certain matters of interest to Her Most Gracious Majesty, of the one part, and the said Indians of the other;

And whereas the said Indians have been notified and informed by Her Majesty's said Commissioners that it is the desire of Her Majesty to open up for settlement, immigration and such other purposes as to Her Majesty may seem meet, a tract of country, bounded and described as hereinafter mentioned, and to obtain the consent thereto of her Indian subjects inhabiting the said tract, and 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;

And whereas the Indians of the said tract, duly convened in council as aforesaid, and being requested by Her Majesty's Commissioners to name certain Chiefs and head men, who should be authorized, on their behalf, to conduct such negotiations and sign any treaty to be founded thereon, and to become responsible to Her Majesty for the faithful performance by their respective bands of such obligations as shall be assumed by them, the said Indians have thereupon named for that purpose, that is to say:—representing the Indians who make the treaty at Carlton, the several Chiefs and Councillors who have subscribed hereto, and representing the Indians who make the treaty at Fort Pitt, the several Chiefs and Councillors who have subscribed hereto;

And thereupon, in open council, the different bands having presented their Chiefs to the said Commissioners as the Chiefs and head men, for the purposes aforesaid, of the respective bands of Indians inhabiting the district hereinafter described;

And whereas the said Commissioners then and there received and acknowledged the persons so represented, as Chiefs and head men, for the purposes aforesaid, of the respective bands of Indians inhabiting the said district hereinafter described;

And whereas the said Commissioners have proceeded to negotiate a treaty with the said Indians, and the same has been finally agreed upon and concluded as follows, that is to say:

The Plain and Wood Cree Tribes of Indians, and all other the Indians inhabiting the district hereinafter described and defined, do hereby cede, release, surrender and yield up to the Government of the Dominion of Canada for Her Majesty the Queen and her successors forever, all their rights, titles and privileges whatsoever, to the lands included within the following limits, that is to say:

Commencing at the mouth of the river emptying into the north-west angle of Cumberland Lake, thence westerly up the said river to the source thence on a straight line in a westerly direction to the head of Green Lake, thence northerly to the elbow in the Beaver River, thence down the said river northerly to a point twenty miles from the said elbow; thence in a westerly direction, keeping on a line generally parallel with the said Beaver River (above the elbow), and about twenty miles distance therefrom, to the source of the said river; thence northerly to the north-easterly point of the south shore of Red Deer Lake, continuing westerly along the said shore to the western limit thereof, and thence due west to the Athabaska River, thence up the said river, against the stream, to the Jasper House, in the Rocky Mountains; thence on a course south-eastwardly, following the easterly range of the Mountains, to the source of the main branch of the Red Deer River; thence down the said river, with the stream, to the junction therewith of the outlet of the river, being the outlet of the Buffalo Lake; thence due east twenty miles; thence on a straight line south-eastwardly to the mouth of the said Red Deer River on the South Branch of the Saskatchewan River; thence eastwardly and northwardly, following on the boundaries of the tracts conceded by the several Treaties numbered Four and Five, to the place of beginning;

And also all their rights, titles and privileges whatsoever, to all other lands, wherever situated, in the North-West Territories, or in any other Province or portion of Her Majesty's Dominions, situated and being within the Dominion of Canada;

The tract comprised within the lines above described, embracing an area of one hundred and twenty-one thousand square miles, be the same more or less;

To have and to hold the same to Her Majesty the Queen and her successors forever;

And Her Majesty the Queen hereby agrees and undertakes to lay aside reserves for farming lands, due respect being had to lands at present cultivated by the said Indians, and other reserves for the benefit of the said

Indians, to be administered and dealt with for them by Her Majesty's Government of the Dominion of Canada, provided all such reserves shall not exceed in all one square mile for each family of five, or in that proportion for larger or smaller families, in manner following, that is to say:—

That the Chief Superintendent of Indian Affairs shall depute and send a suitable person to determine and set apart the reserves for each band, after consulting with the Indians thereof as to the locality which may be found to be most suitable for them;

Provided, however, that Her Majesty reserves the right to deal with any settlers within the bounds of any lands reserved for any band as she shall deem fit, and also that the aforesaid reserves of land or any interest therein may be sold or otherwise disposed of by Her Majesty's Government for the use and benefit of the said Indians entitled thereto, with their consent first had and obtained; and with a view to show the satisfaction of Her Majesty with the behavior and good conduct of her Indians, she hereby, through her Commissioners, makes them a present of twelve dollars for each man, woman and child belonging to the bands here represented, in extinguishment of all claims heretofore preferred;

And further, Her Majesty agrees to maintain schools for instruction in such reserves hereby made, as to her Government of the Dominion of Canada may seem advisable, whenever the Indians of the reserve shall desire it;

Her Majesty further agrees with her said Indians that within the boundary of Indian reserves, until otherwise determined by her Government of the Dominion of Canada, no intoxicating liquor shall be allowed to be introduced or sold, and all laws now in force or hereafter to be enacted to preserve her Indian subjects inhabiting the reserves or living elsewhere within her North-West Territories from the evil influence of the use of intoxicating liquors, shall be strictly enforced;

Her Majesty further agrees with her said Indians that they, the said Indians, shall have right to pursue their avocations of hunting and fishing throughout the tract surrendered as hereinbefore described, subject to such regulations as may from time to time be made by her Government of her Dominion of Canada, and saving and excepting such tracts as may from time to time be required or taken up for settlement, mining, lumbering or other purposes by her said Government of the Dominion of Canada, or by any of the subjects thereof, duly authorized therefor, by the said Government;

It is further agreed between Her Majesty and her said Indians, that such sections of the reserves above indicated as may at any time be required for public works or buildings of what nature soever, may be appropriated for that purpose by Her Majesty's Government of the Dominion of Canada, due compensation being made for the value of any improvements thereon;

And further, that Her Majesty's Commissioners shall, as soon as possible after the execution of this treaty, cause to be taken, an accurate census of all the Indians inhabiting the tract above described, distributing them in

families, and shall in every year ensuing the date hereof, at some period in each year, to be duly notified to the Indians, and at a place or places to be appointed for that purpose, within the territories ceded, pay to each Indian person the sum of five dollars per head yearly ;

It is further agreed between Her Majesty and the said Indians that the sum of fifteen hundred dollars per annum, shall be yearly and every year expended by Her Majesty in the purchase of ammunition and twine for nets for the use of the said Indians, in manner following, that is to say :—In the reasonable discretion as regards the distribution thereof, among the Indians inhabiting the several reserves, or otherwise included herein, of Her Majesty's Indian Agent having the supervision of this treaty ;

It is further agreed between Her Majesty and the said Indians that the following articles shall be supplied to any band of the said Indians who are now cultivating the soil, or who shall hereafter commence to cultivate the land, that is to say :—Four hoes for every family actually cultivating, also two spades per family as aforesaid ; one plough for every three families as aforesaid, one harrow for every three families as aforesaid ; two scythes, and one whetstone and two hayforks and two reaping-hooks for every family as aforesaid ; and also two axes, and also one cross-cut saw, and also one hand-saw, one pit-saw, the necessary files, one grindstone and one auger for each band ; and also for each Chief, for the use of his band, one chest of ordinary carpenter's tools ; also for each band, enough of wheat, barley, potatoes and oats to plant the land actually broken up for cultivation by such band ; also for each band, four oxen, one bull and six cows, also one boar and two sows, and one handmill when any band shall raise sufficient grain therefor ; all the aforesaid articles to be given *once for all* for the encouragement of the practice of agriculture among the Indians ;

It is further agreed between Her Majesty and the said Indians, that each Chief, duly recognized as such, shall receive an annual salary of twenty-five dollars per annum ; and each subordinate officer, not exceeding four for each band, shall receive fifteen dollars per annum ; and each such Chief and subordinate officer as aforesaid, shall also receive, once every three years, a suitable suit of clothing, and each Chief shall receive, in recognition of the closing of the treaty, a suitable flag and medal, and also, as soon as convenient, one horse, harness and waggon ;

That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by her Indian Agent or Agents, will grant to the Indians assistance of such character and to such extent as her Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians from the calamity that shall have befallen them ;

That during the next three years, after two or more of the reserves hereby agreed to be set apart to the Indians, shall have been agreed upon and surveyed, there shall be granted to the Indians included under the Chiefs adhering to the treaty at Carlton, each spring, the sum of one thousand

dollars to be expended for them by Her Majesty's Indian Agents, in the purchase of provisions for the use of such of the band as are actually settled on the reserves and are engaged in cultivating the soil, to assist them in such cultivation ;

That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians, at the discretion of such Agent ;

That with regard to the Indians included under the Chiefs adhering to the treaty at Fort Pitt, and to those under Chiefs within the treaty limits who may hereafter give their adhesion hereto (exclusively, however, of the Indians of the Carlton Region) there shall, during three years, after two or more reserves shall have been agreed upon and surveyed, be distributed each spring among the bands cultivating the soil on such reserves, by Her Majesty's Chief Indian Agent for this treaty in his discretion, a sum not exceeding one thousand dollars, in the purchase of provisions for the use of such members of the band as are actually settled on the reserves and engaged in the cultivation of the soil, to assist and encourage them in such cultivation ;

That, in lieu of waggons, if they desire it, and declare their option to that effect, there shall be given to each of the Chiefs adhering hereto, at Fort Pitt or elsewhere hereafter (exclusively of those in the Carlton District) in recognition of this treaty, so soon as the same can be conveniently transported, two carts, with iron bushings and tires ;

And the undersigned Chiefs, on their behalf, and on behalf of all other Indians inhabiting the tract within ceded, do hereby solemnly promise and engage to strictly observe this treaty, and also to conduct and behave themselves as good and loyal subjects of Her Majesty the Queen ;

They promise and engage that they will in all respects obey and abide by the law, and they will maintain peace and good order between each other, and also between themselves and other tribes of Indians, and between themselves and others of Her Majesty's subjects, whether Indians or whites, now inhabiting or hereafter to inhabit any part of the said ceded tracts, and that they will not molest the person or property of any inhabitant of such ceded tracts, or the property of Her Majesty the Queen, or interfere with or trouble any person passing or travelling through the said tracts or any part thereof ; and that they will aid and assist the officers of Her Majesty in bringing to justice and punishment any Indian offending against the stipulations of this treaty, or infringing the laws in force in the country so ceded.

In witness whereof, Her Majesty's said Commissioners and the said Indian Chiefs have hereunto subscribed and set their hands, at or near Fort Carlton, on the day and year aforesaid, and near Fort Pitt on the day above aforesaid.

(Signed) ALEXANDER MORRIS,
Lieut.-Governor, N.-W. T.

APPENDIX 5

SECTIONS OF THE CONSTITUTION ACT, 1982, PERTAINING TO ABORIGINAL PEOPLES

25 The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including:

(a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and

(b) any rights or freedoms that may be acquired by the aboriginal peoples of Canada by way of land claims settlements.

35(1) The existing aboriginal and treaty rights of the aboriginal peoples in Canada are hereby recognized and affirmed.

35(2) In this Act, 'aboriginal peoples of Canada' includes the Indian, Inuit and Metis peoples of Canada.

37(1) A constitutional conference composed of the Prime Minister of Canada and the first ministers of the provinces shall be convened by the Prime Minister of Canada within one year after this Part comes into force.

37(2) The conference convened under subsection (1) shall have included in its agenda and item respecting constitutional matters that directly affect the aboriginal peoples of Canada, including the identification and definition of the rights of those peoples to be included in the Constitution of Canada, and the Prime Minister of Canada shall invite representatives of those peoples to participate in discussions on that item.

37(3) The Prime Minister of Canada shall invite elected representatives of the governments of the Yukon Territory and the Northwest Territories to participate in the discussions on any item on the agenda of the conference convened under subsection (1) that, in the opinion of the Prime Minister, directly affects the Yukon Territory and the Northwest Territories.

APPENDIX 6

GOVERNMENT OF CANADA
INDIAN HEALTH POLICY (1979)

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

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

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

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

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

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

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

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

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

APPENDIX 7

WINNIPEG REGIONAL HEALTH AUTHORITY
SUMMARY OF JURISDICTIONAL REVIEWS

Summary of Recommendations on Jurisdictional Issues in Health
Past Reports/Consultations/Forums

Royal Commission on Aboriginal People (1993):

- Governments act promptly to:

  (a) conclude agreements recognizing their respective jurisdictions in areas touching directly on Aboriginal health;

  (b) agree on appropriate arrangements for funding health services under Aboriginal jurisdiction; and

  (c) establish a framework, until institutions of Aboriginal self-government exist, whereby agencies mandated by Aboriginal governments or identified by Aboriginal organizations or communities can delivery health and social services operating under provincial or territorial jurisdiction. (3.3.3)

- Federal, Provincial and territorial governments collaborate with Aboriginal nations, organizations or communities, as appropriate to:

  (a) develop a system of healing centres to provide direct services, referral and access to specialist services;

  (b) make the service network available to First Nations, Inuit and Metis communities, in rural and urban settings, on an equitable basis. (3.3.6)

- Federal, provincial and territorial governments collaborate with Aboriginal nations, regional Aboriginal service agencies, community governments and Aboriginal organizations, as appropriate, to adapt legislation, regulations and funding to promote;

  (a) integrated service delivery that transcends restricted service mandates to separate ministries and departments;

  (b) collaboration and shared effort between federal, provincial/territorial and local governments; and

(c) the pooling of resources flowing from federal, provincial, territorial, municipal, or Aboriginal sources. (3.3.7)

- Aboriginal organizations, regional planning and administrative bodies and community governments currently administering health and social services transform current programs and services into more holistic delivery systems that integrate or co-ordinate separate services (3.3.8)

- Federal, provincial and territorial governments, in consultation with Aboriginal nations and urban communities of interest, co-operate to establish procedures and funding to support needs assessment and planning initiatives by Metis and other Aboriginal collectives, in rural and urban settings, to....(3.3.9)

Canadian Medical Association (Bridging the Gap):

- Take action to support Aboriginal peoples in those areas of social, political and economic life that would improve the health of their communities.

- Settle the issue of land use and self-determination as soon as possible – work toward resolving issues of self-determination for Aboriginal peoples and their communities in areas of social, political and economic life.

- Encourage and support Aboriginal peoples in their quest for resolution of self-determination and land use.

Manitoba Health (Quality Care for Manitobans: The Action Plan for the New Millenium)

- Manitoba has accepted the challenge to find ways to overcome jurisdictional barriers and to forge new partnerships to establish an Aboriginal health strategy

Priorities for Action: Towards a Strategy for Aboriginal People Livingin Winnipeg

- Improve co-ordination among governments and community health care providers to address jurisdictional dispute and improve service delivery

- Ensure the acceptance of Aboriginal people in decision making processes that lead to policy development and resource allocation

- Encourage greater access to information and participation of Aboriginal people in health care decision making process

APPENDIX 8

CONSENT FORM

Jurisdiction and First Nations Health and Health Care
Participant Information and Consent Form

Study Investigator: Dr. Catherine Cook

Address: University of Manitoba

750 Bannatyne Avenue

Winnipeg, Manitoba

R3C 0W9

Phone: (204) 926-8099

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with me.

Purpose of the Study

This is a study on how the health care delivery system presently works for First Nation peoples in the province of Manitoba, and a review of any potential gaps in service or barriers to service that arise as a result of unresolved jurisdictional issues at the federal and provincial government levels.

This project will review the key areas of: Public Health services available to First Nation peoples on reserve, the Home Care supports available for First Nation peoples on and off reserve, and transportation services for individuals requiring access to medical care.

The purpose of this study is to review the jurisdictional issues between the Federal and Provincial governments and their level of responsibility as it relates to service delivery for First Nation peoples. It will identify any gaps in service, or barriers to service as a result of unresolved jurisdictional issues. Issues around barriers, such as poor or lack of accessibility to medical or supportive care, or gaps in service which impact on the health care delivery to First Nation peoples, will be discussed in interviews between voluntary participants and the interviewer. The results of this study may be used to assist in program development that is controlled by First Nations.

Study Procedures

We will ask to interview you and the interview will take place wherever the volunteer feels most comfortable. The interview will be taped, and the interviewer will be taking notes. This will ensure that the information is not written down incorrectly or inaccurately. All information you provide in this interview will be kept strictly confidential and summary reports of the information provided by all participants will be compiled.

All the information shared will be kept strictly confidential and individuals, their roles, and their communities or departmental affiliation will be kept anonymous. Individual names will not be used. The information will be reported in general terms to demonstrate their perceptions of how service is delivered.

As part of this study, we ask your permission to use documents such as organizational reports and ask that you provide access to information tht you feel may be relevant to this study. All interview information will be analyzed and will have no person identifiers. The data will be analyzed to illustrate key themes that emerge from the interviews. To ensure that you are not identified through the interview, your name will be kept separate from the interview and transcripts, and will be kept in a locked cabinet. Upon transcription of the audiotapes, they will be erased.

Risks

The stakeholder group involved in providing health services for Aboriginal peoples is small. As a result, there is potentially a risk that events or activities on which you report may be recognizable or linked to you, just as other persons mentioned may also be identifiable. We cannot guarantee absolute confidentiality.

Costs

There are no costs to you for participating in this study. You will receive no payment, and you will not receive reimbursement for any expense related to taking part in this study.

Benefits

There may not be any direct benefit to you for participating in this study. This information may be useful to the First Nation peoples who are involved in the organization, development, implementation and provision of community health services. It may also be useful to those governments and administrators, as well as health care providers who are responsible for the organization and delivery of services within the system.

Payment

You will receive no payment or reimbursement for any expenses related to participating in this study.

Confidentiality

Information gathered in this study will be published by the University as a completed thesis. Your name, or other identifying information will not be used or revealed. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed.

Voluntary Participation/Withdrawal from the Study

Volunteers have the right to refuse to participate. If they do agree to participate, they can refuse to answer any question they want. Participants are allowed to withdraw from the Study at any time after they have signed the consent. Trained interpreters will be used in the interviews where language barriers exist.

Questions

You are free to ask any questions that you may have about your rights as a research participant.

Do not sign this consent form unless you have had a chance to ask questions andhave received satisfactory answers to all of your questions.

Statement of Consent

Participant:

I have read this consent form. I have had the opportunity to discuss this study. I have had any questions answered in the language I understand. The risks and benefits have been explained to me. I will be given a copy of the consent form after signing it.

My participation in this study is voluntary, and I may choose to withdraw at any time. I understand that I can refuse to answer any questions or withdraw from the study at any time. I understand that everything I say will be treated as confidential and will only be used in a general way. I understand that individual names will not be used, and my personal identity will be kept confidential, but that confidentiality is not guaranteed.

Before the final information is presented, I shall have a chance to read the report and talk about any changes I think are necessary. All the volunteers involved will receive a final copy of the report. A presentation of the final results will be available for those who wish.

Date: _____

Participant Signature: _____

Participant Printed Name: _____

Research Staff:

Investigator:
I have fully explained the relevant details of this study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Date: _____

Signature: _____

Printed Name: _____

Interpreter:
I have interpreted the information in the language of the participant's choice and I believe the participant has understood and has knowingly given their consent.

Date: _____

Signature: _____

Printed Name: _____

APPENDIX 9

INTERVIEW PROTOCOL

Format: semi-structured

Duration: one – two hours

Setting: chosen by the informant

Themes: Perceptions of the Current Health Care Delivery Structure

- Jurisdictional responsibility
- Accountability and availability of services
- Roles and responsibilities
- Integrity and responsiveness of the system

Barriers to Service or Gaps in Service for First Nations

- Accessibility to service
- Appropriateness of service
- Difficulties encountered in accessing service
- Specific areas

Strategies for the Future

APPENDIX 10

NON-INSURED HEALTH BENEFITS TABLES
SOURCE: NON-INSURED HEALTH BENEFITS ANNUAL REPORT

Table 1: Eligible Client Population by Region

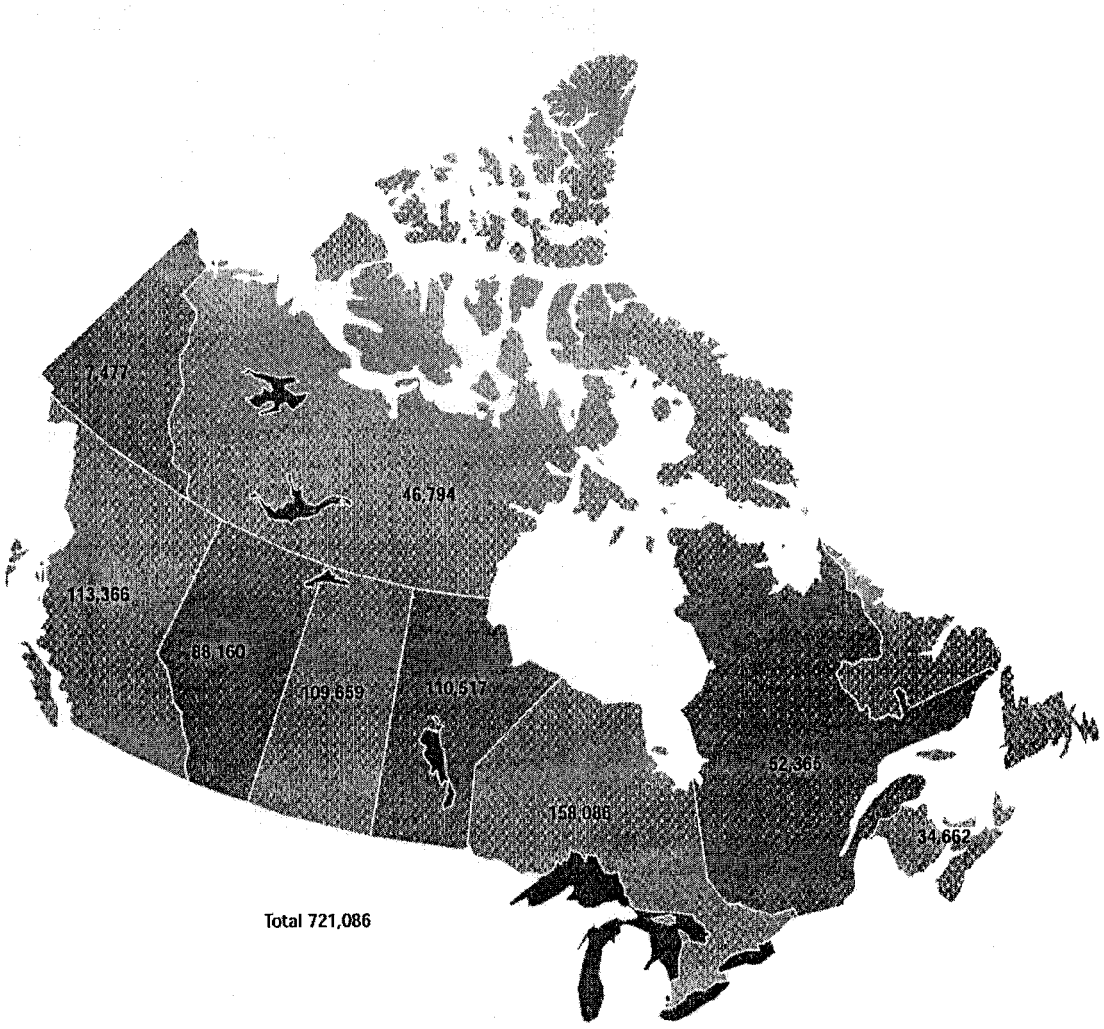

Table 2: Eligible Client Population by Region 1998 – 2002

REGION	March/98	March/99	March/00	March/01	March/02
Atlantic	32,514	32,484	33,211	33,910	34,662
Quebec	48,905	49,791	50,745	51,593	52,365
Ontario	143,603	147,385	151,741	155,443	158,086
Manitoba	98,725	101,319	104,821	107,777	110,517
Saskatchewan	98,481	101,639	104,180	107,105	109,659
Alberta	78,901	80,981	83,596	85,908	88,160
Pacific	105,475	107,512	109,847	111,562	113,366
Yukon	7,063	7,159	7,272	7,373	7,477
N.W.T. & Nunavut	42,710	43,906	44,738	45,667	46,794
Total	**656,377**	**672,176**	**690,151**	**706,338**	**721,086**
Annual % change	**2.5%**	**2.4%**	**2.7%**	**2.3%**	**2.1%**

Table 3: Annual Expenditures by Benefit

All Regions

BENEFIT	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Transportation	$ 104,531	$ 113,844	$ 128,007	$ 139,400	$ 150,019	$ 157,472	$ 165,686	$ 166,229	$ 177,078	$ 182,851	$ 195,719
Pharmacy	104,415	120,856	133,481	146,131	157,297	166,541	180,105	187,105	206,869	228,861	252,846
Dental	84,427	97,976	110,346	116,273	123,303	104,302	104,420	106,417	106,975	109,852	124,468
Other Health Care	36,675	41,196	36,735	32,150	27,307	21,824	21,748	19,847	16,108	16,775	14,135
Premiums	22,797	24,387	26,350	28,610	30,094	22,125	17,131	17,476	18,030	17,779	18,596
Vision Care	17,744	16,386	14,101	16,040	17,242	17,017	18,576	18,490	19,843	19,748	22,020
Total	$ 370,589	$ 414,645	$ 449,020	$ 478,604	$ 505,262	$ 489,281	$ 507,666	$ 515,564	$ 544,903	$ 575,866	$ 627,784
Annual % Change	20.9%	11.9%	8.3%	6.6%	5.6%	-3.2%	3.8%	1.6%	5.7%	5.7%	9.0%

Table 4: Annual Expenditures in Manitoba Region by Benefit

	Manitoba Region											
BENEFIT	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Transportation	$ 21,605	$ 24,037	$ 29,345	$ 32,431	$ 37,672	$ 40,379	$ 43,520	$ 40,499	$ 44,413	$ 46,089	$ 48,320
Pharmacy	15,045	13,472	19,889	20,142	21,286	21,647	24,805	25,395	31,132	35,533	36,078
Dental	9,248	10,927	10,467	13,054	14,734	11,171	11,575	11,836	10,189	11,832	16,319
Other Health Care	5,962	6,940	4,721	5,431	6,099	6,330	7,164	6,624	4,399	3,218	4,023
Vision Care	1,640	2,337	1,551	1,305	2,114	1,788	2,128	2,034	1,899	1,748	2,860
Total	$ 53,500	$ 57,713	$ 65,973	$ 72,363	$ 81,905	$ 81,315	$ 89,192	$ 86,388	$ 92,032	$ 98,420	$ 107,600
Annual Percentage Change	30.7%	7.9%	14.3%	9.7%	13.2%	-0.7%	9.7%	-3.1%	6.5%	6.9%	9.3%

Table 5: Expenditures by Benefit and Region

REGION	Transportation	Pharmacy	Dental	Other Health Care	Premiums	Vision Care	TOTAL
Atlantic	$ 6,234,500	$ 12,667,100	$ 5,195,700	$ 173,300	$ —	$ 1,433,400	**$ 25,704,000**
Quebec	16,589,400	22,208,600	10,505,400	543,300	—	1,119,000	**50,965,700**
Ontario	40,264,200	51,166,900	27,568,300	2,182,800	—	4,886,300	**126,068,500**
Manitoba	48,320,200	36,078,000	16,318,700	4,023,500	—	2,859,600	**107,600,000**
Saskatchewan	23,862,200	38,240,100	15,707,600	2,663,300	—	3,113,100	**83,586,300**
Alberta	29,796,500	36,780,500	16,680,000	3,371,100	8,914,300	4,396,800	**99,939,200**
Pacific	14,038,900	33,591,700	18,230,600	1,164,500	9,681,800	2,622,000	**79,329,500**
Yukon	2,019,600	2,648,600	1,283,800	13,100	—	199,300	**6,164,400**
N.W.T. & Nunavut	14,594,300	8,382,700	8,228,400	—	—	1,390,500	**32,595,900**
Headquarters	—	11,081,400	4,749,200	—	—	—	**15,830,600**
Total	$195,719,800	$252,845,600	$124,467,700	$ 14,134,900	$ 18,596,100	$ 22,020,000	$627,784,100

Table 6: Per Capita Expenditures by Region

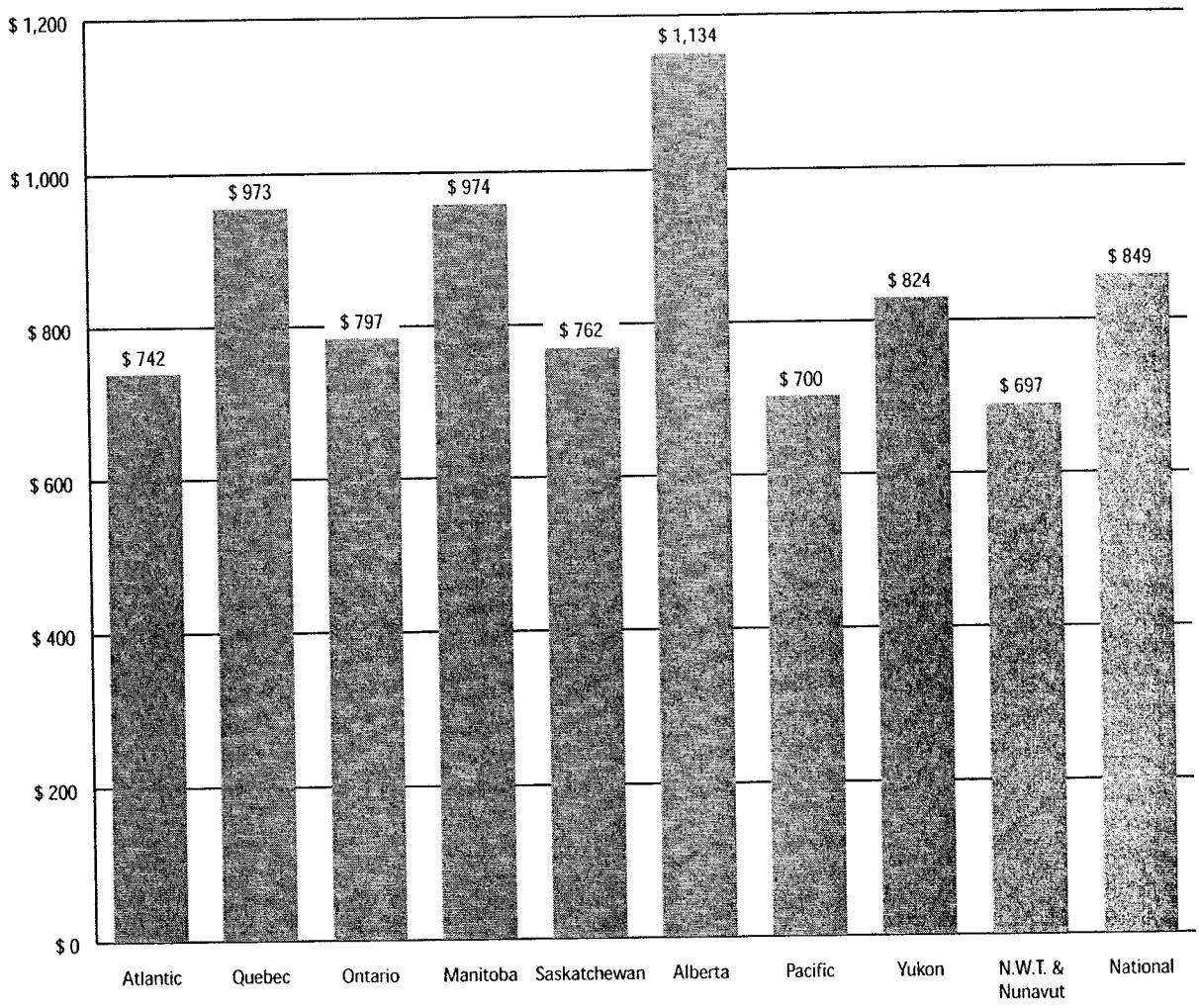

Table 7: Dental and Pharmacy Utilization Rates

REGION	Dental Utilization					Pharmacy Utilization				
	1997/98	1998/99	1999/00	2000/01	2001/02	1997/98	1998/99	1999/00	2000/01	2001/02
Atlantic	41%	38%	40%	39%	39%	62%	61%	60%	59%	58%
Quebec	46%	45%	49%	47%	48%	64%	64%	63%	63%	62%
Ontario	32%	31%	33%	31%	32%	60%	57%	57%	56%	**56%**
Manitoba	29%	24%	27%	23%	22%	71%	70%	70%	68%	68%
Saskatchewan	37%	35%	39%	38%	39%	82%	79%	82%	79%	**78%**
Alberta	44%	42%	46%	43%	43%	83%	80%	80%	78%	**77%**
Pacific	43%	42%	43%	39%	40%	71%	70%	69%	67%	**66%**
Yukon	36%	34%	39%	32%	36%	60%	59%	61%	61%	**61%**
N.W.T. & Nunavut	43%	42%	40%	40%	43%	44%	44%	44%	44%	**45%**
Total	**38%**	**36%**	**38%**	**36%**	**36%**	**69%**	**67%**	**67%**	**65%**	**65%**

Table 8: Total Pharmacy Expenditures by Type and Region

REGION	Operating								Contributions	
	Prescription Drugs	OTC Drugs	Drugs/MS&E Regional	Medical Supplies	Medical Equipment	Other Costs	Total Operating	Contribution Agreements	Total Costs
Atlantic	$ 8,583,800	$ 1,839,600	$ 45,600	$ 296,700	$ 526,100	$ 0	$ 11,291,800	$ 1,375,300	$ 12,667,100
Quebec	18,516,100	2,868,400	32,700	285,800	487,800	0	22,190,800	17,800	22,208,600
Ontario	39,020,400	7,089,200	175,000	851,400	2,084,500	0	49,220,500	1,946,400	51,166,900
Manitoba	26,821,700	6,194,700	800	1,059,500	1,875,200	0	35,951,900	126,100	36,078,000
Saskatchewan	27,702,500	6,837,700	950,600	1,033,000	1,680,000	0	38,203,800	36,300	38,240,100
Alberta	27,261,000	4,103,500	1,058,700	1,176,600	3,180,700	0	36,780,500	0	36,780,500
Pacific	26,773,100	3,307,200	133,200	729,300	2,231,300	0	33,174,100	417,600	33,591,700
Yukon	2,140,800	180,200	124,800	40,900	161,900	0	2,648,600	0	2,648,600
N.W.T. & Nunavut	6,889,600	786,900	0	365,600	305,600	0	8,347,700	35,000	8,382,700
Headquarters	0	—	—	—	—	11,081,400	11,081,400	0	11,081,400
Total	$ 183,709,000	$ 33,207,400	$ 2,521,400	$ 5,838,800	$ 12,533,100	$ 11,081,400	$ 248,891,100	$ 3,954,500	$ 252,845,600

Table 9: Total Dental Expenditures by Type and Region

REGION	Operating				Contributions	
	Fee-For-Service	Contract Dentists	Other Costs	Total Operating	Contribution Agreements	Total Costs
Atlantic	$ 5,089,300	$ 0	$ 2,800	$ 5,092,100	$ 103,600	**$ 5,195,700**
Quebec	10,314,000	130,300	61,100	10,505,400	0	**10,505,400**
Ontario	22,070,300	1,459,000	57,700	23,587,000	3,981,300	**27,568,300**
Manitoba	10,431,900	3,147,900	400	13,580,200	2,738,500	**16,318,700**
Saskatchewan	14,845,400	59,700	5,200	14,910,300	797,300	**15,707,600**
Alberta	16,390,200	280,000	9,800	16,680,000	0	**16,680,000**
Pacific	18,118,800	111,700	100	18,230,600	0	**18,230,600**
Yukon	1,273,800	9,400	600	1,283,800	0	**1,283,800**
N.W.T & Nunavut	7,211,300	0	0	7,211,300	1,017,100	**8,228,400**
Headquarters	—	—	4,749,200	4,749,200	0	**4,749,200**
Total	**$ 105,745,000**	**$ 5,198,000**	**$ 4,886,900**	**$ 115,829,900**	**$ 8,637,800**	**$124,467,700**

Table 10: Expenditures in Medical Transportation – Type and Region 2001/02

Schedule Airline	$ 317,400	$ 251,800	$ 7,425,700	$ 10,197,100	
Chartered Flights	9,500	20,200	6,247,600	11,634,100	
Living Expenses	197,000	11,900	2,854,000	5,317,800	
Land&Water	2,227,800	654,600	3,728,100	6,313,900	
Outside Canada	0	0	500	0	
Other Operating	0	0	0	0	
Total Operating	**$ 2,751,700**	**$ 938,500**	**$ 20,255,900**	**$ 33,462,900**	
Contributions	**3,482,800**	**15,650,900**	**20,008,300**	**14,857,300**	
Total	**$ 6,234,500**	**$ 16,589,400**	**$ 40,264,200**	**$ 48,320,200**	
% Change from 00/01	**2.2%**	**7.2%**	**14.8%**	**4.8%**	

TYPE	Saskatchewan	Alberta	Pacific	Yukon	N.W.T & Nunavut	Total
Schedule Airline	$ 2,092,300	$ 63,600	$ 611,100	$ 605,400	$ 0	$ 21,564,400
Chartered Flights	2,814,900	1,465,300	38,300	878,100	0	23,108,000
Living Expenses	992,600	1,981,900	586,800	343,300	0	12,285,300
Land&Water	11,921,600	11,764,200	927,800	192,800	0	37,730,800
Outside Canada	1,600	0	0	0	0	2,100
Other Operating	0	0	0	0	0	0
Total Operating	**$ 17,823,000**	**$ 15,275,000**	**$ 2,164,000**	**$ 2,019,600**	**$ 0**	**$ 94,690,600**
Contributions	**6,039,200**	**14,521,500**	**11,874,900**	**0**	**14,594,300**	**101,029,200**
Total	**$ 23,862,200**	**$ 29,796,500**	**$ 14,038,900**	**$ 2,019,600**	**$ 14,594,300**	**$ 195,719,800**
% Change from 00/01	**-2.4%**	**6.0%**	**10.4%**	**9.0%**	**12.3%**	**7.0%**