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Towards the Adoption of a National Aboriginal Health Policy

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Introduction

The current Canadian health system consists of many interrelated elements that are the responsibility of the federal, territorial, provincial, and municipal governments, Aboriginal authorities, or the private sector (Wigmore and Conn 2003). Legislation, policies, relationships, and goodwill are what glue the system together. In some cases, this results in a relatively seamless system. In most cases, however, the system is at best loosely woven, resulting in gaps and ambiguities (Marchildon 2005, 1–150).

It is generally acknowledged that the fragmented nature of the health-care system—to which jurisdictional issues add complexity and confusion—creates a patchwork of policies and programs for Aboriginal peoples (Government of Canada 1997; National Advisory Committee on SARS and Public Health 2003; Romanow 2002). This was highlighted by the Assembly of First Nations' report "First Nations Public Health Framework" (Assembly of First Nations 2006), the Métis National Council's "Métis Health Research Project" (Canada 2005, 181), and the Inuit Tapiriit Kanatami's report, "Backgrounder on Inuit Health" (Inuit Tapiriit Kanatami 2004).

The authors recently completed the Policy Synthesis Project on behalf of the National Collaborating Centre for Aboriginal Health.¹ The objective of this project was to identify existing national, provincial, and territorial Aboriginal health policies in place in Canada.

The word "policy" is often used to mean public decisions, positions, and statements/announcements of government direction by an elected official or a senior government official. These occur at all levels of the health-care system. A policy may be created as a result of legislation, other legal documents (court case, treaty), or simply because of an identified organizational need. Federal, provincial, and territorial governments have umbrella policies, meaning policies that apply across departments or ministries. For example, Manitoba Health has a series of policies that applies across all regional health authorities (RHAs). These policies clearly define areas of regional autonomy for the RHAs. Likewise, the federal government has adopted policies and guidelines that inform issues related to public expenditures for all federal departments. Policies also emerge in different sectors

Table 9.1: Definitions of Policy

Names	Definition	Examples
Big-“P” policies High-politics policies Macro or systemic policies	National or provincial public policies	The 1979 Indian Health Policy
Small-“P” policies Low-politics policies Sectorial or micro policies	Health organizations’ internal functioning policies	A hospital’s early discharge policy; or program eligibility rules

Source: Lavoie 2005; Walt 1988

of the health-care system such as hospitals and health departments, to entrench a decision that serves the needs of that organization.

Table 9.1 provides examples. The Policy Synthesis Project focuses on existing big-“P” policies and legislation. Legislative and policy frameworks are long-term commitments, usually supported by funding. They play an important role in maintaining the coherence of health-care systems and in delineating objectives of Aboriginal, national, territorial, or provincial significance. They also play an important role in entrenching value-based principles, such as equity, responsiveness, and public participation.

It is important to recognize that significant work related to Aboriginal health occurs outside of any legislative and policy frameworks. This may include the establishment of collaborative policy-making processes, partnerships between Aboriginal communities and regional health boards, the creation of new programs and new delivery models to ensure responsiveness, etc. While it could be argued that these initiatives may be in place as a matter of policy, these policies may be unwritten, regional in scope, informal, or not publicly available. Documenting these was considered outside the scope of the Policy Synthesis Project. It would be a monumental task, as this work is largely undocumented, and often limited to goodwill-based initiatives that exist outside of legislative and formal policy frameworks. Finally, the initiatives may be short-lived, as they are the most vulnerable to budget cuts, changes in government and staff, and other pressures.

In some cases, goodwill-based initiatives and relationships mitigate policy shortfalls and facilitate access. While helpful, it can be argued that vesting access to essential health services in goodwill is a concern. Vesting access to essential health services in goodwill for a culturally and ethnically-identifiable segment of the Canadian population is problematic, and counters the principles of the *Canada Health Act*, 1984. Finally, this approach has shown to be insufficient. Evidence suggests that access to health-care services continues to be problematic for Aboriginal peoples (Adelson 2005, 96: S45-S61).

The purpose of this paper is to attempt to answer the question: *If what we have in Canada is an Aboriginal health policy patchwork that fails to address inequities, then what would a healthy Aboriginal Health Policy framework look like?*

To commence answering this question, this paper begins with a brief discussion of the methodology and terminology adopted for the study. This is followed by a section that explores federal, territorial, and provincial Aboriginal health policies that were in place in 2007–08, highlighting strengths and gaps. A final section discusses the need for the adoption of a Canada-wide Aboriginal health policy, based on common principles that nevertheless reflect the diversity of Aboriginal peoples.

Methodology

The data reported in this paper is based on information that is publicly available on the World Wide Web. The choice to focus on Internet searches was based on a number of factors. First, the decision was made to limit this project to publicly and readily available information to ensure consistency. Second, the Internet is an important tool of policy research and information for policy-makers, researchers, users, and many government departments. Third, expanding this project to include documents that are not readily available on the Internet would have required identifying key collaborators within each government department and training them to ensure consistency in information gathering. This would have required considerably more resources and time to possibly yield little more than what was available on the Internet.

The data for this project was compiled over a one-year period (March 2007 to April 2008). Internet searches included word searching the following terms and combinations of these words: Aboriginal, First Nation(s), Inuit, Metis or Métis, Indian, Amérindiens, Reserve, Health, and Medical. Lower case was used to avoid problems retrieving data from casesensitive search engines.

Key websites explored included: the Parliamentary Library; Health Canada; the Public Health Agency of Canada (PHAC); Indian and Northern Affairs Canada (INAC); Department of Justice Canada; Statistics Canada; the Aboriginal Canada Portal; provincial and territorial websites including Ministries/Departments of Aboriginal Affairs, Ministries/Departments of Health; and Aboriginal organizations.

The data is compiled in a report available at www.nccah.ca. As stated, this project is based on information that was publicly available on the World Wide Web during a specific period of time. The Internet is, however, a challenging research tool. The information is forever shifting and no consistent method for referencing has been uniformly adopted. Accuracy is at times difficult to ascertain, and must be checked against numerous sources. Further, there is no way to be confident that the record is complete. The data reported here may therefore have gaps in information.

A Word on Terminology

In Canada, the term “Aboriginal” is used as an collective term encompassing Indians, Inuit, and Métis, as entrenched in the Canadian Constitution as amended in 1982. The term glosses over cultural, legislative, and administrative complexities. For the purpose of this paper, the term “Aboriginal” is used only when statements apply to First Nations living on- and off-reserve, Inuit, Métis and non-status individuals of First Nations ancestry. In other cases, self-referents are used. The term “Indian” was used only when quoting historical documents or when referring to the *Indian Act*’s legal term “Indians” which defines access to certain federal programs and benefits.

The term “First Nations” is the preferred self-referent used by the Indigenous peoples of Canada historically known as “Indians.” It, too, is a collective term that veils a multiplicity of nations, including Nisga’a, Cree, Ojibway, Salish, Mohawk, Mi’kmaq, and Innu, to name a few. From an administrative perspective, there are currently more than six hundred First Nations recognized by the federal government (Canada 2006b). These are political and administrative organizations that emerged to satisfy the requirements of the *Indian Act*.²

Eligibility for registration/status can be lost. Under certain circumstances, such as through Bill C-31, it can be gained (White et al. 2007).³

Some First Nations communities have argued that federal criteria fail to be inclusive of their membership. As a result, some communities have expanded their membership rules to include those of common ancestry that may not be eligible for registration as Indians under the *Indian Act*. Nevertheless, the federal government understands its responsibility for financing health services and other programs to be limited to those registered as Indians (Lavoie et al. 2005).

Inuit is the collective self-referent of the Arctic peoples. Inuit themselves recognize local groups with different names (Pallurmiut, Inuvialuit, etc.), reflecting the complexity of Arctic history and subtlety in cultural differences that are often glossed over by outsiders. Most Inuit live in one of four Inuit regions: Inuvialuit in the Northwest Territories, Nunavut, Nunavik in Québec, and Nunatsiavut in Newfoundland and Labrador. All have been involved in self-government activities. Provisions entrenched in the *Indian Act* have been extended to Inuit since 1939. INAC keeps a separate Inuit registry, which defines an Inuk⁴ as the child of an Inuk (Ontario Aboriginal Health Advocacy Health Initiative 1999). Mixed ancestry does not impact Inuit’s eligibility to be registered to the same extent as it impacts Indians.

The Red River region, located north of what is now Winnipeg, is often viewed as the geographic birthplace of the Métis. According to the Métis National Council, the Métis people emerged out of the relations of Indian women and European men, prior to Canada’s crystallization as a nation, in west central North America. While the initial offspring of these Indian and European unions were individuals who possessed mixed ancestry, the gradual establishment of distinct Métis

communities, outside of Indian and European cultures and settlements, as well as the subsequent intermarriages between Métis women and Métis men, resulted in the genesis of a new Aboriginal people—the Métis.

Distinct Métis communities emerged as an outgrowth of the fur trade along some parts of the freighting waterways and Great Lakes of Ontario, throughout the northwest and as far north as the McKenzie river. The Métis people and their communities were connected through the highly mobile fur-trade network, seasonal rounds, extensive kinship connections, and a collective identity (i.e., common culture, language, way of life, etc.). They developed their own blended culture and their own language, Michif (or Metchif). After Confederation, the Métis were not entitled to sign treaties. Like non-status Indians, themselves descendents of status Indians and non-Aboriginals, Métis do not benefit from the special provisions made by the federal government for a number of programs, including community-based health services (Metis National Council 2008).

Increasingly, a number of Métis communities are being recognized both loosely (as within Ontario) and legislatively in Alberta. In the latest census report, Statistics Canada documents communities containing 25% or more Métis residents (Statistics Canada 2008).

Documents and policies use two variations for the spelling of the word: Métis and Metis. For consistency, throughout this project, the spelling Métis was adopted unless the alternate spelling appears in a direct citation.

Findings

This section summarizes key findings in two specific areas. First, it documents the jurisdictional patchwork by exploring legislation and policies containing Aboriginal-specific provisions. Second, it explores the limitations of the patchwork by highlighting areas of jurisdictional shifts and ambiguity.

The starting point of any discussion on jurisdiction is the *Constitution Act, 1867*, which established that Indians were a federal jurisdiction. In the 1939 decision, *Re: Eskimos (Re: Eskimos, [1939] S.C.R. 104, [1939] 2 D.L.R. 417)*, the Supreme Court of Canada settled the issue and determined that the Inuit were “Indians” under the *British North America Act, 1867* and thus, also a federal responsibility. At the macro or big-“P” policy level and arguably as a result of the *Constitution Act, 1867*,⁵ the federal government has primary responsibility for a complement of health services provided to registered Indians living on-reserve and to Inuit living in their traditional territories in Québec and Labrador. Only one program applies to all registered Indians and to Inuit, regardless of where they live: the Non-Insured Health Benefits (NIHB) program. With regards to health services however, this responsibility does appear to depend on areas of residency; registered Indians living off-reserve and Inuit living outside of their traditional territories receive health services from the provincial or territorial health authorities, or from providers paid by the provincial or territorial authority.

Provincial and territorial governments are responsible for the delivery of a number of health services, as defined by the *Canada Health Act 1984*, complemented by services designed to meet territorial or provincial priorities. Métis, off-reserve registered Indians, non-registered Indians, and Inuit living outside of their traditional territories fall under the purview of territorial and provincial governments. Since the level of services delivered in different provinces/territories may vary, the level of services provided to Aboriginal people as residents across provinces and territories will also vary. While relatively clear theoretically, a number of intersecting federal, provincial, and territorial legislation, policies, and authorities with shifting and blurred responsibilities contribute to ambiguities and gaps. This following discussion focuses specifically on the Aboriginal health policy “patchwork,” and reports on (a) the health legislative frameworks in place at the federal level, in the territories and provinces, and the Aboriginal-specific provisions that are stated in legislation; and (b) the health policy frameworks in place at the federal level, in the territories and provinces, and the Aboriginal-specific provisions that are stated in policies.

At the national level, the legislative authority for the federal government’s obligation for Indian health is spelled out in Section 73 of the *Indian Act*, which gives the Governor in Council the authority to make regulations,

- (f) to prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable;
- (g) to provide medical treatment and health services for Indians;
- (h) to provide compulsory hospitalization and treatment for infectious diseases among Indians;
- (i) to provide for the inspection of premises on reserves and the destruction, alteration or renovation thereof;
- (j) to prevent overcrowding of premises on reserves used as dwellings;
- (k) to provide for sanitary conditions in private premises on reserves as well as in public places on reserve (Canada 1985).

It should be noted that the *Indian Act*’s regulation-making power does not outline obligations, nor does it provide sufficient authority for a comprehensive public health and health services regulatory framework on First Nations reserves. The Act does not contain specific provisions for Inuit peoples, although they are presumably included based on the 1939 court case previously mentioned.

There are only two publicly available national Aboriginal health policies: the 1979 Indian Health Policy and the 1989 Health Transfer Policy. The Indian Health Policy was adopted on September 19, 1979 (Crombie 1979). The policy was a two-page document with one broad-based objective:

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. (Health Canada 2005a)

It listed three pillars from which to improve Indian health:

- Increase the health status of Indian communities, through mechanisms generated and maintained by the communities themselves;
- Strengthen traditional and new relationships between Federal, Provincial, and local governments and Indians' Government organizations by encouraging greater involvement in the planning, budgeting and delivery of health programs; and,
- Increase the capacity of Indian communities to play a positive and active role within the Canadian Health Care System and with decisions affecting their health. (Health Canada 2005b)

There is ambiguity as to the range of application of the Indian Health Policy, because the text of the policy does not specify whether it is inclusive of registered and non-registered Indians, nor does it make mention of Inuit peoples.

The Health Transfer Policy is the most tangible outcome of the Indian Health Policy. The Health Transfer Policy, rolled out in 1989, provided opportunities for single communities and Tribal Councils to assume the responsibility for the planning and delivery of community-based health services, as well as some regionally-based programs (Lavoie et al. 2005). The objective of the policy was to promote community uptake of community-based health services, as well as some regional programs provided by the First Nation and Inuit Health Branch of Health Canada (FNIHB). The Health Transfer Policy applies to First Nations on-reserve and to the Inuit of Labrador only.

Section 35 of the *Constitution Act 1982* recognizes and affirms existing Aboriginal and treaty rights. It further recognized First Nations, Inuit, and the Métis as Aboriginal peoples. Although the *Constitution Act* did not include a provision for self-government, since 1995 the Government of Canada has had a policy recognizing the inherent right of self-government under Section 35 (Indian and Northern Affairs Canada 1995). This provision has informed the negotiation of self-government agreements. Although the policy does not contain a specific provision for health services, health services have been included in agreements south of sixth parallel. The health provisions adopted in these self-government agreements have been modeled on provisions embedded in the Health Transfer Policy. Health services have not been included in self-government agreements signed in the territories. It is unclear whether health services could be included in Métis self-government agreements signed with Métis living in the provinces.

The Public Health Agency of Canada (PHAC) was created in 2004 by an Act of Parliament (Canada 2006a), following the 2003 severe acute respiratory syndrome (SARS) outbreak. The report of the National Advisory Committee on SARS and Public Health (2003) pointed out that the federal-provincial

jurisdictional fragmentation over Aboriginal peoples' health care is a public health concern that creates barriers to access health services. PHAC currently offers a number of off-reserve health programs. The programs are specifically designed to meet the needs of marginalized populations, including Aboriginal people living off-reserve. The PHAC 2007 to 2012 Strategic Plan states that PHAC plans to increase its capacity in Aboriginal health and to develop a strong, overarching, strategic Aboriginal public health policy. To do this, PHAC proposes to launch and maintain collaborative relationships with national and regional Aboriginal organizations and other federal departments (Canada 2007, 32). Provincial and territorial jurisdictions are not mentioned.

As can be seen from the discussion above, the federal policy framework informing issues of jurisdiction over Aboriginal health is thin and loosely woven. The framework is silent on the Métis and on those who are not eligible for registration as Indians under the *Indian Act*. The policy framework does not link to a legislative framework, other than the *Indian Act* and the *Canada Health Act 1984*. Provisions under these Acts are broadly worded, and subject to interpretation.

Provincial and Territorial Jurisdiction

Findings for territorial and provincial health legislative frameworks are summarized in **Table 9.2**. As shown, no specific provisions exist in the health legislation of the Northwest Territories, Nunavut, British Columbia, Manitoba, Nova Scotia and/or Prince Edward Island to clarify the responsibilities of these territories and provinces in terms of Aboriginal health. Where provisions exist, they focus on jurisdiction: for example, legislation in Alberta is said to apply to Métis settlements (Alberta 2006).

The Alberta Public Health Act

65 (1) When an order is issued under section 62 in respect of patented land as defined in the Métis Settlements Act, the regional health authority may submit a notice of health hazard to the Registrar of the Métis Settlements Land Registry and the Registrar shall record the notice against the Métis title register for the land that is subject to the order.

(2) A notice of health hazard recorded under this section does not lapse and shall not be cancelled except on the receipt by the Registrar of the Métis Settlements Land Registry, of a notice in writing from the regional health authority requesting cancellation.

Table 9.2: Legislative Policy and Patchwork: The Territories and Provinces (Part One)

Province/ Territory	No specific provisions in health legislation to clarify responsibilities in Aboriginal health	Provisions stating that the minister may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services	Provision clarifying the application of legislation on Métis settlements	Health legislation containing provisions related to existing modern treaties	Territory/province-wide Aboriginal health framework	Health legislation recognizing the need to respect traditional healing practices	Provisions that recognize that Aboriginal traditional healers should be exempted from control specified under the Code of Professions	Tobacco control legislation that specifies that the legislation does not apply to the use of tobacco for ceremonial purposes
YK				Provisions exist		Provisions exist		
NWT	No provision				Policy framework exists			
NU	No provision							
BC	No provision				Policy framework exists			
AB		Provisions clarify jurisdiction on First Nation reserves	Provisions exist					
SK		Provisions clarify jurisdiction on First Nation reserves						Provisions exist

Table 9.2: Legislative Policy and Patchwork: The Territories and Provinces (Part Two)

Province/ Territory	No specific provisions in health legislation to clarify responsibilities in Aboriginal health	Provisions stating that the minister may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services	Provision clarifying the application of legislation on Métis settlements	Health legislation containing provisions related to existing modern treaties	Territory/province-wide Aboriginal health framework	Health legislation recognizing the need to respect traditional healing practices	Provisions that recognize that Aboriginal traditional healers should be exempted from control specified under the Code of Professions	Tobacco control legislation that specifies that the legislation does not apply to the use of tobacco for ceremonial purposes
MB	No provision							Provisions exist
ON		Provisions clarify jurisdiction on First Nation reserves			Policy framework exists		Provisions exist for traditional healers and midwives	Provisions exist
QC				Provisions exist				
NB		Provisions clarify jurisdiction on First Nation reserves						Provisions exist
NS	No provision				Policy framework exists			
PEI	No provision							Provisions exist
NL				Provisions exist				

(3) On recording a notice of health hazard, the Registrar of the Métis Settlements Land Registry shall notify the person against whose Métis title the notice is recorded and every person who has recorded an interest against the Métis title. (Alberta 2000b)

Alberta, Saskatchewan, Ontario, and New Brunswick legislation specifically states that the minister may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services, thereby clearly indicating that the provisions of services on-reserve is outside of the province's mandate.

The Alberta Hospitals Act

Part 3 - Hospitalization Benefits Plan states that the Minister may on behalf of the Government of Alberta enter into an agreement with the Government of Canada providing for the making of contributions by Canada to Alberta in respect of the costs incurred by Alberta in providing insured services to Indians residing in Indian reserves in Alberta. (Alberta 2000a)

The Saskatchewan Public Health Act, 1994

For the purpose of carrying out this Act according to its intent, the minister may enter into agreements with a local authority, the Government of Canada or its agencies, the government of another province or territory of Canada or its agencies, an Indian band or any other person. (Saskatchewan 1994)

The Ontario Long-Term Care Act

(7) The Minister shall designate as a multi-service agency,

(a) an approved agency that is an organization operating under the authority of a First Nation, if the Minister has entered into an agreement with the First Nation under clause 9 (1) (a) and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement;

(b) an approved agency that is an organization operating under the authority of a group of First Nations, if the Minister has entered into an agreement with the group of First Nations under clause 9 (1) (b) and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement;

(c) an approved agency that is an organization operating under the authority of an aboriginal community, if the Minister has entered into an agreement under clause 9 (1) (c) with the approved agency or an aboriginal organization other than the approved agency and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement. (Ontario 1994)

The New Brunswick Public Health Act

58(1) The Minister may, subject to the approval of the Lieutenant-Governor in Council, enter into and amend an agreement with

(c) a band council as defined in the Indian Act (Canada), a municipality or a rural community...

This is for the purpose of organizing and delivering public health programs and services, the prevention of diseases and injuries, and/or the promotion and protection of the health of the people of New Brunswick or any group of them. (New Brunswick 1998)

Health legislation in the Yukon, Quebec, and Newfoundland and Labrador contain provisions related to existing self-government agreements and modern treaties, thereby clarifying these territory/provinces' roles and responsibilities in health only in the areas included in these agreements. For example, while the *Yukon Health Act* stipulates the importance of partnerships with Aboriginal groups and the respect of traditional Aboriginal healing, it also stipulates that the Yukon Land Claim Agreement or the Yukon First Nations Self-Government Agreement shall prevail in a conflict (Yukon 2002). The 1991 *Loi sur les services de santé et les services sociaux* defines a process for handling complaints related to access to services for signatories of the James Bay and Northern Québec Agreement. Similar provisions exist in Newfoundland & Labrador:

The Newfoundland and Labrador Health and Community Services Act

2.1 This Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land

Claims Agreement Act shall have precedence over the provision of this Act. (Newfoundland and Labrador 1995)

Some legislation includes provisions related to traditional practices. The Yukon is the only jurisdiction where health legislation recognizes the need to respect traditional healing practices, and the importance of establishing partnerships with Aboriginal peoples (Yukon 2002). Ontario recognizes that Aboriginal midwives and traditional healers should be exempted from control specified under the Code of Professions. Specific provisions are listed under the *Midwifery Act* (Ontario 1991). Finally, Saskatchewan, Manitoba, Ontario, New Brunswick, and Prince Edward Island have adopted tobacco control legislation that specifies that the legislation does not apply to the use of tobacco for ceremonial purposes (Manitoba 2004; New Brunswick 2004; Ontario 2006b; Prince Edward Island 2006; Saskatchewan 2001).

Our investigation also shows the existence of a limited number of Aboriginal-specific policies/frameworks. Ontario was the first province to develop an Aboriginal Health and Wellness Strategy in 1990, and to develop an overarching Aboriginal Health Policy in 1994 (Ontario Aboriginal Health Advocacy Health Initiative 1999). The Aboriginal Health Policy is intended to act as a governing policy and assist the Ministry of Health in accessing inequities in First Nation/Aboriginal health programming, responding to Aboriginal priorities, adjusting existing programs to respond more effectively to needs, supporting the reallocations of resources to Aboriginal initiatives, and improving interaction and collaboration between ministry branches to support holistic approaches to health. This is the most comprehensive policy framework currently in place in Canada. It is perhaps as a result of this policy of Aboriginal engagement that Ontario is also the only jurisdiction to have developed a comprehensive Health Plan for an Influenza Pandemic, with a section specific to First Nations communities. The plan outlines emergency pandemic procedures and policies, and identifies the needs of First Nations communities during an influenza pandemic. It also clarifies the roles and responsibilities of the Ontario Ministry of Health and Long-Term Care, First Nations and Inuit Health (FNIH), and First Nations communities in responding to an influenza pandemic (Ontario 2006a).

The Northwest Territories is the only jurisdiction with a Métis Health Policy (Northwest Territories Health and Social Services 2008). The policy is, however, limited to extending access to Non-Insured Health Benefits as provided to registered Indians.

In British Columbia, the 2005 Transformative Change Accord and the First Nations Health Plan form a tripartite First Nations policy framework that aims to close the disparities that exist between First Nations and other British Columbians in the areas of health, education, and housing. The framework also intends to clarify issues of Aboriginal titles and jurisdiction. The framework explicitly applies to First Nations, and does not address the needs of other Aboriginal groups

in British Columbia (First Nations Leadership Council, Canada, and British Columbia 2006).

A similar framework was developed in Nova Scotia. The 2005 Providing Health Care, Achieving Health—Mi'kmaq focuses on the specific needs of the Mi'kmaq people, however, it does not address the needs of the Métis and other Aboriginal peoples living in Nova Scotia (Mi'kmaq, Nova Scotia, and Canada Tripartite Forum 2005, 58).

The data explored above constitutes the Aboriginal health and policy framework that exists in the provinces and territories. It shows that, although progress has been made in the development of legislation and policies that contain Aboriginal-specific provisions, what remains is very much a jurisdictional patchwork. Legislative frameworks show little evidence of concern for addressing Aboriginal needs. The main focus remains the clarification of jurisdiction, and even that is partial. Policy frameworks are few. While progress has been made, there is considerable variation from one province/territory to the next and significant gaps.

When taken together, federal and provincial/territorial legislative and policy frameworks fail the test of seamlessness. They also fail to address shifts in jurisdictions related to changes in legislation or as a result of new arrangements. Areas that are particularly problematic are highlighted below.

Subpopulations poorly served by the current frameworks include First Nations individuals who are recognized as a member of a First Nation through Band rules, but are nevertheless not eligible for registration under the *Indian Act*. Funding for health services is, however, calculated on the basis of the population actually served only in communities where services are provided by nursing stations (16% of First Nations communities).⁶ In all other communities, the FNIHB funds communities for services delivered to registered Indians only (Lavoie et al. 2005). The number of children and adults who are not eligible for registration under the *Indian Act* as a result of Bill C-31, and who nevertheless live on-reserve, is growing (Clatworthy and Four Directions Project Consultants 2001b; 2001c). In terms of health services, these individuals exist in jurisdictional limbo. First Nations organizations must decide to provide services for all, at a loss, or to provide services only to those members for whom they receive funding, while remaining politically accountable to all members and thereby risking political fallout.

There is a growing number of Aboriginal individuals of First Nations ancestry who live off-reserve and who do not qualify for registration under the *Indian Act*. Although the responsibility for providing care to these individuals falls under the purview of the provinces and territories, the responsiveness of provincial services in particular has been questioned. Research continues to show that tacit and sometimes overt discriminatory practices and policies continue to marginalize many Aboriginal people in the mainstream health-care system (Benoit, Carroll, Chaudhry 2003; Browne 2007; Culhane D. 2003; Dion, Stout, and Kipling 1998; Kaufert and Putsch 1997; Smith et al. 2006). With the exception of Ontario, and

emerging dialogues in Nova Scotia and British Columbia, current policies and legislation have yet to entrench provisions to improve the responsiveness of provincial health services.

A variety of new arrangements have emerged in the past three decades, adding further complexity to jurisdictional issues. Some of these arrangements are the result of modern treaties and self-government activities. In some areas, the numbered treaties signed between 1870 and 1929 remain the most current expression of self-government activities.⁷ In others, modern treaties have been signed that clarify areas of ambiguities embedded in historical treaties (for example, Canada, Government of Northwest Territories, and Tlicho 2003). Modern treaties have also been signed in areas where historical treaties had never been negotiated (for example, the James Bay and Northern Quebec Agreement, Canada 1974; the Nunavut Lands Claim Agreement, Canada 1993; and the Agreement with the Nisga'a Nation, Canada, and British Columbia 1999). Every modern treaty and self-government agreement has resulted in different arrangements. For example, all four Inuit regions have engaged in self-government activities, resulting in increased autonomy in key areas. The Nunavut Land Claim Agreement resulted in the creation of the territory of Nunavut. In the Inuvialuit and Nunatsiag regions, Inuit have signed self-government agreements. In Nunavik, the James Bay and Northern Quebec Agreement gave rise to a unique model whereby Inuit-managed structures that resulted from this agreement (the health board, the school board) were seen as extensions of the provincial government's own structures. An agreement signed in 2007 will lead to the creation of the Regional Government of Nunavik, which will have oversight of all Nunavik structures created as a result of the James Bay and Northern Quebec Agreement. This new order of government will answer directly to the National Assembly of Quebec (Indian and Northern Affairs Canada 2007).

Self-government agreements and modern treaties have established Aboriginal government's jurisdiction in health. Health-care structures that emerged as a result of the James Bay and Northern Quebec Agreement are somewhat unique in Canada, in that these structures are co-funded by the federal and provincial governments to serve the health-care needs of Nunavik Inuit and the James Bay Cree (Canada 1974). These structures are extensions of the provincial health-care system. The Nisga'a Valley Health Authority in British Columbia and the Athabasca Health Authority in Saskatchewan are other examples of Aboriginal health authorities that are at least partially funded by the federal government and are extensions of a provincial health-care system (Athabasca Health Authority 2006; Nisga'a Nation, Canada, and British Columbia 1999). Further, the Nisga'a Agreement, the James Bay and Northern Quebec Agreement, and the Labrador Inuit Association Agreement are tripartite agreements that include provisions for self-administration of health services. The new arrangements include provisions that clarify jurisdiction, and roles and responsibilities, as well as mechanisms to address jurisdictional issues as they emerge. Still, each agreement is somewhat

unique, thereby creating somewhat different arrangements and obligations. To date, Newfoundland and Labrador and Quebec have responded by embedding provisions in their legislation to clarify issues of jurisdiction resulting from the signature of modern treaties. The same can be said for the Yukon. Some provinces (Alberta, Saskatchewan, Ontario, and New Brunswick) have adopted provisions stating that the minister may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services, thus providing a mechanism for clarifying issues of jurisdiction in communities where self-government agreements have been signed. Other provinces have remained silent on this matter.

Recently, cross-jurisdictional mechanisms have emerged in a few provinces. Examples include the Saskatchewan Northern Health Strategy, which brings together First Nations, Métis, northern municipalities, Regional Health Authorities, and federal and provincial authorities. Its purpose is to explore areas of collaboration, improve the continuum of care for all northerners, design strategies to better use existing resources, and resolve cross-jurisdictional issues. The Manitoba Inter-Governmental Committee on First Nations Health was set up in 2003 to identify priorities and coordinate approaches to improve First Nations health in Manitoba. The committee's membership includes representatives from the Assembly of Manitoba Chiefs, the Manitoba Keewatinook Ininew Okimowin, the Southern Chiefs Organization Inc., First Nations and Inuit Health Manitoba Region, the Public Health Agency of Canada, Manitoba Health, the Manitoba Department of Aboriginal and Northern Affairs, Family Services and Housing Manitoba, Manitoba Finance, and Indian and Northern Affairs Canada. Still, these mechanisms are not empowered to change legislation and adopt policies, and their effectiveness in addressing cross-jurisdictional issues is constrained by existing legislation, policies, and budgets that are decided at the national and provincial levels.

The analysis provided above suggests that although some areas of jurisdiction are clear or clearer, shifts related to changes in the *Indian Act*, new Aboriginal self-governments, and tripartite agreements to improve access to health services have added (and will continue to add) complexities. This suggests that some Aboriginal health jurisdictional boundaries will continue to shift and blur over time. Finally, this analysis suggests that jurisdiction needs not only be defined in legislation and in policy, but that it also needs to be managed as an ongoing environment that shifts over time. Some organizational mechanism, such as a commission or council is required, and at this point such a body does not exist.

Discussion

This Policy Synthesis Project indicates that over the past forty years, considerable efforts have been made to include Aboriginal-specific provisions in legislation, and to develop Aboriginal-specific policies. Significant gaps and jurisdictional ambiguities, however, remain. Further, policy frameworks have largely ignored

the needs of Aboriginal peoples not eligible for registration under the *Indian Act* or who are Métis.⁸

Inequalities continue to exist in an ever-changing health-care system that operates with multiple jurisdictional actors. This is the environment that existed in 1966 when jurisdictional issues were first raised (Hawthorn 1966), that continues to exist (Government of Canada 1997; National Advisory Committee on SARS and Public Health 2003; Romanow 2002), and that will need to be considered in future health planning. Options for managing this environment include:

(a) Waiting for the adoption of a full Constitutional package that provides guidance on these issues

(b) Continuing to “patch” the patchwork, recognizing that this is how the current system emerged and that this approach has failed to yield the anticipated benefits

(c) Removing ambiguities in the system by designing rigid definitions of jurisdiction that may nevertheless result in new gaps emerging as a result of changing environments

(d) Guiding all jurisdictions through the adoption of a national Aboriginal health policy framework, informed by shared principles to guide policy development at all levels

It is our contention that the development of a National Aboriginal Health Policy is crucial to realizing improvements in Aboriginal health through the federal, provincial, and territorial health-care systems. Of course, accomplishing such an objective is not simple. Two broad challenges will need to be addressed. First, the federal-provincial jurisdictional divide is often believed to preclude the adoption of nationwide approaches that nevertheless are expected to influence provincial and territorial governments in an area that is defined in the *Constitution Act* as provincial jurisdiction. While the concern is legitimate, the example of the *Canada Health Act 1984* illustrates that a national act can effectively guide provincial and territorial health-care systems through voluntary membership, shared principles, and financial incentives. The *Canada Health Act* may serve as a model for the adoption of a National Aboriginal Health Policy that federal departments, territories, and provinces may voluntarily sign onto in their commitment to close jurisdictional gaps and health inequalities. Possible principles to be a part of this national policy may include:

(a) A recognition that Aboriginal peoples are diverse, and that flexibility will be required to address needs

(b) A statement based on Section 35 of the Constitution that recognizes Aboriginal peoples’ right to self-government

(c) A recognition of Indigenous determinants of health (Reading, Kmetc, and Gideon 2007, 1-81)

(d) A commitment to the Jordan Principle⁹ (Lavallee 2005, 10:527-529)

The second challenge comes from First Nations, Inuit, and Métis themselves who have rejected pan-Aboriginal approaches en bloc, and who may object to the adoption of a national Aboriginal approach simply because it is likely to gloss over key differences, contexts, and priorities. The concern is valid and important, however, it may not be a significant obstacle if engagement occurs at the onset, and if the output—the policy—provides opportunities for First Nations, Inuit, and Métis to pursue their priorities, based on their values and aspirations. The experience of the past forty years should have taught us that critical and systematic engagement is the only mechanism that will yield a credible product, and is the only way forward.

Endnotes

- 1 The National Collaborating Centre for Aboriginal Health is one of six national collaborating centres established by the Public Health Agency of Canada to renew and strengthen public health in Canada. This project has been made possible through a financial contribution from the Public Health Agency of Canada. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.
- 2 The federal government distinguishes between registered (or status) and non-registered (or non-status) Indians. The terms “registered” and “status” are used interchangeably. A registered Indian is a person registered as an Indian under the terms of the *Indian Act*. Registration ensures the right to live on-reserve and access to treaty and/or policy-defined benefits. Class 24 of Section 91 of the *Constitution Act, 1867* recognizes registered Indians as a federal responsibility. Non-registered Indians are a provincial jurisdiction. These distinctions tend to blur in the territories, as territorial governments use more inclusive rules of eligibility for their programs.
- 3 Editor’s Note: These issues are complex and if the reader wishes to explore the current practices and problems, see White et al. *Aboriginal Policy Research, Volume 5*, Thompson Educational Publishing 2007.
- 4 Inuit is the plural form. Inuk is the singular.
- 5 The federal government still argues that its provision of health services on-reserve is for humanitarian and historical reasons. It rejects a policy or legal obligation.
- 6 The type of services funded by FNIHB on reserves is based on community size and remoteness. Local services range from health promotion and public health delivered by nurses and community health representatives (health centres), in some communities on a part-time basis only (health station and health offices), to community health nursing and primary care delivered by nurses with an expanded scope of practice (nursing stations).
- 7 We acknowledge that historical treaties may not be understood as expression of self-government at all, given the context in which they were signed.
- 8 Editor’s Note: Most jurisdictions simply cover these individuals under the general public medicare schemes. This does ignore special problems associated with the specific group.
- 9 Editor’s Note: Jordan’s Principle refers to putting the child first in treatment decisions. Where a jurisdictional dispute arises around government services to a status Indian or Inuit child, Jordan’s Principle calls for the government department of first contact to pay for the service without any delay. The paying department can then refer the matter to existing inter-governmental processes to determine who might ultimately continue payments and cover initial expenses.

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