

A First Nations Voice in the Present Creates Healing in the Future

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ABSTRACT

This paper discusses the urgency for change and improvements in health policy determined by the exploding demographics and inequities in the health status of First Nation people. A historical overview of health services for First Nation clients was conducted as set out through government legislation and health and social policies.

Until WWII ended, the federal government provided assistance to First Nations through Indian Affairs branches of several departments. This responsibility was gradually transferred to National Health and Welfare. In 1962, the federal government established a Medical Services Branch, later renamed First Nations and Inuit Health Branch, and mandated to provide services to First Nation clients, which fell outside the provincial jurisdiction of health care. Initially centered on public health priorities, services have expanded to include primary health care, dental, mental health, environmental health, home and continuing care, and Non-Insured Health Benefits.

The Romanow Report substantiated the urgency for health policy improvements voiced by many First Nations. However, it generalized Aboriginal issues in health care on a national front. Furthermore, its recommendations were specific to health care providers and delivery models and did not address the social and spiritual determinants of health, which are fundamental to a First Nations' holistic approach. Health planners must think holistically, considering traditional and westernized medicine, First Nations' values, priorities and government systems, and present and evolving health systems. Universities, health authorities, provinces and the federal government are continually developing new research and health models, which will also need consideration. Further, the imperative of involving community-level input must be recognized.

MeSH terms: First Nation; provincial government; federal government; jurisdiction

La traduction du résumé se trouve à la fin de l'article.

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While Canada is attempting to revitalize its universal health care system to ensure its sustainability, Manitoba First Nations are working with federal and provincial associates to address the health crisis of First Nations. The Grand Chiefs of the three political organizations, the Assembly of Manitoba Chiefs (AMC), the Manitoba Keewatinook Ininew Okimowin (MKIO) and the Southern Chiefs Organization (SCO), pressed for a partnership response to the federally commissioned *The Future of Health Care in Canada*,¹ commonly referred to as the Romanow Report. Manitoba promoted this approach, and assigned its Health and Aboriginal and Northern Affairs departments, while Canada joined later with representatives from Indian and Northern Affairs Canada and Health Canada. The proposed framework of this tripartite approach is to offer fundamental change to improve the health status of First Nations people. This is a long-overdue endeavour and an exciting challenge.

This paper will discuss the urgency for change and improvements in health policy determined by the exploding demographics and inequities in the overall health status of First Nation people. It will also provide a historical overview of health services to First Nation clients as set out through government legislation and health and social policies. It will conclude by identifying optimistic opportunities for change for First Nations people in Manitoba, while respecting their cultural diversities.

Demographics and health status

First Nations are the largest of the three constitutionally recognized Aboriginal peoples in Canada. Within Manitoba, the Cree (mid north and north), Dakota and Assiniboine (southwest), Dene (far northwest), Ojibway (south) and Oji-Cree (mid northeast) are the indigenous peoples of Manitoba who have contributed greatly to the economy and vitality of Manitoba and Canada through community and individual achievements, traditional and westernized knowledge, philosophy, arts, science, and culture. First Nations do share a belief in a holistic and balanced approach to life as necessary to maintain good health. Yet the diversity of language, culture, geography and history of the 63 First Nation communities necessitates their full involve-

ment in changing policies and approaches in health.

According to the Statistics Canada Aboriginal Peoples Survey 2001,² the Manitoba First Nations population is 107,146, which is approximately 10% of Manitoba's total population with 47% of First Nations people living on reserve. The remaining 53% live in rural communities, often close to their reserve communities, or in urban centres. The median age of Manitoba First Nations people is 22.8 years, while that of the non-Aboriginal population is 38.5 years. Thus, First Nations planning for future employment and services must consider that this youthful population 'bulge' is a decade behind the mainstream population. While mainstream society is concerned with preparing for the retiring baby boomers' needs, including housing for 'empty nesters' and senior homes, First Nations are planning for more schools and family housing.

It is well documented that the health of First Nations lags behind that of the non-Aboriginal population (see Table I). The life expectancy for both First Nation men and women is eight years less than that of the general population.⁸ The prevalence of diabetes is almost four times that of other non-First Nations and this disease is said to have reached epidemic proportions in First Nation communities.⁸

These demographics heighten awareness of the need for culturally appropriate health services, including prevention through addressing the social determinants of health such as the lack of employment, adequate housing and water, and northern food costs and access to traditional foods and medicines off reserve. The Romanow Joint Working Group (RJWG) is expected to consider how such change can be planned and delivered.

Origins of jurisdiction in First Nations health care

First Nations are unique. With the historical distinction of the Dakota, First Nations within Manitoba are also signatories with the Crown to numbered treaties signed in the nineteenth century, and consider health care to be a treaty right. In addition, all First Nations are recognized in s.91(24) of the Constitution Act, 1867, as being under the specific jurisdiction of the federal government. Their Treaty and

TABLE I

Selected Comparisons of the Health of Manitoba First Nations vs. Non-First Nations People

Manitoba	On Reserve		Off Reserve		Non-First Nations	
	Male	Female	Male	Female	Male	Female
Life expectancy (years)	68.8	73.8	67.9	72.8	76.1	81.4
	Total Population		Total Population		Total Population	
Diabetes prevalence		20.3%		17.0%		4.5%
Hypertension prevalence	23.5% (over age of 25)		19.9%		20.2%	
Injury hospitalizations		33.2%		27.0%		8.3%
Selected causes of injury		Falls – 21.0%		21.0%		48.0%
Hospitalizations		Violence by others – 15.1%		20.6%		4.1%
		Violence to self – 14.5%		14.6%		6.3%

Source: Martens P. et al.⁸

Aboriginal rights are "hereby recognized and affirmed" in s.35 of the Constitution Act, 1982. And, as residents of Manitoba, First Nations people are entitled to enjoy services within the five principles of the Canada Health Act, 1984: public administration, comprehensiveness, universality, portability, and accessibility.³ The vast majority of all insured services provided by the provinces occur off reserve, with a few exceptions.

Until WWII ended, the federal government accepted its responsibility to provide assistance to First Nations through Indian Affairs branches of several departments through the years. This responsibility gradually transferred to National Health and Welfare. In 1962, the federal government had established a Medical Services Branch (MSB), which remained until 1998 when it was renamed First Nations and Inuit Health Branch (FNIHB). This branch was mandated to provide those services to First Nation clients which fell outside of the provincial jurisdiction of health care and initially centered on public health priorities, delivered on-reserve.^{4,5} The services have since expanded to include primary health care, dental, mental health, environmental health, home and continuing care, and Non-Insured Health Benefits (NIHB), such as dental and eye care through a national needs-based program.⁶ Health Canada has maintained a very strict policy of delivering services only to Indians on reserves, and has asserted that these services are a matter of policy, not a treaty right. The Province of Manitoba has taken the position that non-insured health services for Status Indians resident on reserve are not a provincial responsibility.⁷ Further to this, they add that the "result has been an impasse regarding a wide range of services for which there are pressing needs."⁷

One might assume that this 'dual' service delivery would ensure coverage of

health and needs from at least one level of government or service provider. Instead, this piecemeal delivery has been linked to significant gaps between the health status of First Nations peoples and that of all other Canadians.⁸ Throughout this jurisdictional interplay, the federal and provincial governments continually seek to find ways in which the other government may pay the costs of services. It is evident that these disputes impede First Nation governments in pursuing positive health status of their people, and in First Nations individuals accessing the health care and preventive measures they need.⁵ This situation is described as "managing services and programs for First Nations people within a system that has, for the last one hundred and fifty years, focussed on divesting itself of the responsibility."⁵

Further confusion exists with regard to social services. While the provinces follow their constitutional responsibility to deliver social services in child protection, income assistance, housing and infrastructure, personal care homes, education, and justice, they have maintained these services off reserve. The federal government develops policy and delivers services on reserve, although in recent years, they have been increasingly funding First Nations or their agencies to administer these programs. In some cases, First Nations have adapted and delivered their own programs to a great extent; however, funding conditions prevent real First Nations control from design to delivery. Today, most First Nations in Manitoba usually deliver their own Child and Family Services (CFS) and education programs on reserve, in addition to some health programs. Income Assistance remains an INAC designed and controlled program, albeit delivered on reserve by First Nations.

In the 1980s, the First Nations and Inuit Health Branch (FNIHB) of Health

Canada began transferring financial and program mandates to First Nations at a community level. First Nations may choose to proceed through four stages of “transfer” of increasing authority. While some 40 of the 63 First Nation communities are in various stages of “transfer”, they express concern about delivering services under the rules of policy and mandate unilaterally decided by the federal government. This practice perpetuates the subordinate role of First Nations as service providers, and does not encourage or invite First Nations to joint decision- or policy-making exercises. The First Nations have voiced their concerns regarding unilateral decision-making, and propose the full scope of autonomy as a self-governing authority. Through the Treasury Board requirement of renewing departmental authorities before March 2005, Health Canada is currently undertaking a national evaluation of the transfer initiatives, with some First Nations participation.

Romanow impact

The Romanow Report shed light on contentious health and social policy from both levels of government, and exposed the effects and inefficiencies of the unilateral and convoluted decision-making powers of governments, pertaining to First Nations health. It substantiated and publicized the urgency for marked improvements, voiced by many First Nations. However, the Romanow Report was criticized for what it did not say. It generalized Aboriginal issues in health care on a national front and made recommendations for pan-Aboriginal policies, when research has shown that there are specific factors affecting the health status of, and outcomes of health care interventions with, First Nations, Inuit and Métis peoples. Furthermore, its recommendations were specific to health care providers and delivery models and did not address the social and spiritual determinants of health, which are fundamental to a First Nations holistic approach. Thus, it failed to incorporate First Nations health perspectives, which seem more in line with a population health approach, encompassing physical, mental, emotional, and social/environmental determinants of health.

Nevertheless, the Romanow Report did call for “innovative solutions” and a new

approach “that tackles the root causes of health problems for Aboriginal peoples, cuts across administrative and jurisdictional barriers, and focuses squarely on improving the health of Aboriginal peoples.” (p.212) It recommended action to:

- “consolidate fragmented funding to take the best advantage of the total potential funds available;
- create new models to co-ordinate and deliver health care services and ensure Aboriginal health needs are addressed;
- adapt health programs and services to the cultural, social, economic and political circumstances unique to different Aboriginal groups; and
- give Aboriginal peoples a direct voice in how health care services are designed and delivered.” (p.212)

The Romanow Report suggested a partnership approach to address the three main options for financing, organizing and delivering health care services to Aboriginal peoples:

- Maintain the status quo in which Health Canada would continue to negotiate individual transfer agreements with communities for the responsibility for delivering health services;
- Link the delivery models to larger objectives of expanding self-government models, as recommended by the Royal Commission on Aboriginal Peoples;⁹ and
- Make Aboriginal health services the responsibility of provincial governments, and integrate them into the provincial health care systems.^{1,10}

Romanow Joint Working Group in Manitoba

In December 2003, the First Nation leadership from the three political and territorial organizations, AMC, MKIO, and SCO, met with the Manitoba Minister of Health and the Manitoba Minister of Aboriginal and Northern Affairs. Discussions focussed on proceeding toward substantive change in improving health status of First Nations peoples, in light of the Romanow Report. There was agreement on a mandate for the establishment of a joint technical working group. They also agreed to extend an invitation to the Federal Ministers of Health Canada and Indian and Northern Affairs Canada. Technical meetings began in March 2003 on a regular basis, with feder-

al civil servants appointed by their Ministers in June 2003. The time is ripe for change and innovative developments are expected to occur through this new tripartite working group, called the Romanow Joint Working Group (RJWG).

The partners have some optimism because of previous partnerships which First Nations and the provincial and federal governments have entered into and which have achieved some positive results. For example, the First Nations Child and Family Service (CFS) agencies and their political organizations, AMC and MKO, have worked with this Manitoba government to follow up on the recommendation of the Aboriginal Justice Inquiry¹¹ to extend the mandate of CFS agencies off reserve. After three years of concerted joint effort, the Child and Family Services Authorities Act was proclaimed in November 2003 and the First Nations CFS agencies are now taking over all cases of their First Nations citizens off reserve. This cooperative action with Manitoba represents one step closer to full First Nations government reaching all their citizens. In another example, the Four Arrows Health Authority, a branch of the Island Lake Tribal Council, is serving the health needs and promoting holistic health to all four First Nation communities in their region. It is funded by FNIHB with some grants from Manitoba Health, and operates under a First Nations Board of Directors.

These partnerships and others have succeeded through the process of building mutual respect and trust. This is no small feat as First Nations have endured a century of dispossession and assimilation, despite assurances by the Crown that they are “acting in good faith”. First Nations leaders are holding federal and provincial authorities accountable, and are pressing for cooperation in achieving responsible First Nations governments serving the best interests of their people.

First Nations are making strides in their attempts to improve their overall health status by tackling the health care system and jurisdictional issues. It is not the intent of this paper to define the First Nation perspective of holistic care, but rather to paint a picture of the overarching issues that affect First Nations’ ability to design and deliver holistic care from the array of

responsible providers and jurisdiction. With this said, First Nations values, no matter what indigenous nation, are founded on respect and responsibility; people are accountable for decisions in life as an individual, and a member of a family, community and nation. However, First Nations people recognize the historical legacy that has resulted in disastrous social and economic conditions in our communities, and have impacted our health status and our indigenous medicine ways. To address health in all its aspects will require adequate and streamlined supports to create a balance between the individual and culturally relevant health systems for these individuals, families, communities and nations.

CONCLUSION

Within the Romanow Joint Working Group, the three parties understand that they will have to think holistically, considering both traditional and westernized medicine, First Nations values, priorities and government systems, present and evolving health systems. The universities, regional health authorities, First Nations and federal and provincial governments are continually developing new research and health models, which will also need consideration in the policy mix. Affiliations with the National Aboriginal Health Organization, the Institute for Aboriginal Peoples Health, and the recent addition of the federally established National Health Council will also assist in evaluating health care services. As the RJWG proceeds, the parties will have many ideas for new models of cooperation and joint action. They understand the imperative of involving community-level input. The policy options and proposed models will be presented to the Manitoba Chiefs in Assembly, and the federal and provincial Ministers for decisions on coordinated action.

First Nations seek substantive change in health outcomes and health care, as Romanow recommended and the federal and provincial governments know must occur. It will require the unfaltering political will of the leadership and nothing short of a paradigm shift in systems thinking among the technicians. The three parties understand what is at stake: the status quo is not an option. As one elder asked, "why are the costs increasing while our people get sicker?" The Romanow Joint Working Group is committed to seeking answers, and identifying and acting on the innovative solutions required.

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RÉSUMÉ

Cet article porte sur l'urgence de changer et d'améliorer les politiques sanitaires, étant donné l'explosion démographique observée chez les Premières nations et les injustices qu'elles vivent sur le plan de la santé. Nous avons fait un survol historique des services de santé à l'intention des Premières nations dans les lois et les politiques gouvernementales sur la santé et les services sociaux.

Jusqu'à la fin de la Deuxième Guerre mondiale, le gouvernement fédéral offrait une aide aux Premières nations par le biais des directions des affaires indiennes de plusieurs ministères. Cette responsabilité a progressivement été dévolue au ministère de la Santé nationale et du Bien-être social. En 1962, le gouvernement fédéral a créé une Direction générale des services médicaux, rebaptisée « Direction générale de la santé des Premières nations et des Inuits » (DGSPNI) par la suite, et lui a confié le mandat de desservir la clientèle des Premières nations, dont les soins de santé n'étaient pas du ressort des provinces. Articulés initialement autour de priorités de santé publique, les services de la DGSPNI ont été étendus aux soins de santé primaires, aux soins dentaires, à la santé mentale, à l'hygiène du milieu, aux soins à domicile et aux soins prolongés, ainsi qu'aux services de santé non assurés.

Le rapport Romanow a confirmé l'urgence d'apporter les améliorations aux politiques sanitaires que réclament de nombreuses Premières nations. Le rapport aborde cependant les problèmes autochtones au chapitre des soins de santé en termes généraux et dans une optique nationale. De plus, ses recommandations portent spécifiquement sur les dispensateurs de soins de santé et les modes de prestation, en négligeant les déterminants sociaux et spirituels de la santé, pourtant à la base de l'approche holistique des Premières nations. Il faudrait que les planificateurs des services de santé aient une pensée holistique qui tienne compte de la médecine traditionnelle et occidentalisée, des valeurs, des priorités et des systèmes de gouvernement des Premières nations, ainsi que des systèmes de santé actuels et en devenir. Les universités, les autorités sanitaires, les provinces et le gouvernement fédéral élaborent constamment de nouveaux modèles de recherche et de santé dont il faut aussi tenir compte. Enfin, il faut reconnaître la nécessité absolue de solliciter l'apport de la communauté.