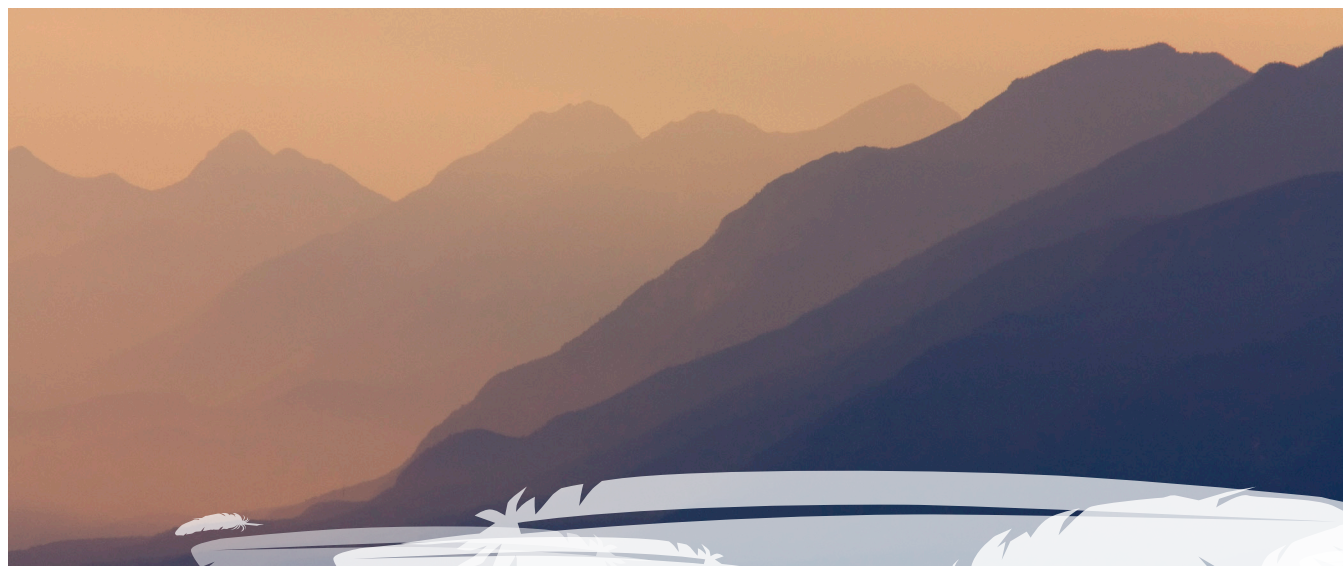


THE ABORIGINAL HEALTH LEGISLATION AND POLICY FRAMEWORK IN CANADA



A synopsis of *Looking for Aboriginal Health in Legislation and Policies: 1970 to 2008*, prepared for the NCCAHC by Josée Lavoie, Laverne Gervais, Jessica Toner, Odile Bergeron and Ginette Thomas

The Canadian health system is a complex patchwork of policies, legislation and relationships. Further complicating the system is the multiplicity of authorities who are responsible for health services and programs: the federal, provincial/territorial, and municipal governments; various Aboriginal¹ authorities; and the private sector (Wigmore & Conn, 2003). Aboriginal health care in Canada has become even more complex as a result of self-government agreements and other mechanisms to expand Aboriginal

peoples' involvement in the provision of locally needed services and programs. Coordinating the needs of Aboriginal communities and various levels of government is an ongoing challenge. This fact sheet examines federal, provincial and territorial health legislation and policies in Canada that contain Aboriginal-specific provisions. It also highlights various models of service and some mechanisms which promote cross-jurisdictional cooperation.

Background

The current context shaping the Aboriginal health legislation and policy environment in Canada takes root in

The Relationship Between Policy and Legislation

Health legislation may be defined as "the body of rules that regulates the promotion and protection of health, health services, the equitable distribution of available resources and the legal position of all parties concerned, such as patients, health care providers, health care institutions and financing and monitoring bodies" (Leenan, 1998). In essence, health policies are not laws and are therefore not enforceable. This makes them easily changed unless they become entrenched as policy objectives in legislation (Legemaate, 2002).

¹ In the context of this paper, the term 'Aboriginal' is used broadly to refer collectively to the Indigenous inhabitants of Canada, including First Nations, Inuit and Métis peoples (as stated in section 35(2) of the Constitution Act, 1982). Wherever possible, we provide names and information for distinct groups/communities.



the 1867 British North America Act (BNA). The Act defined health services as a provincial jurisdiction, and Indian Affairs as an area of federal jurisdiction, thus creating an ambiguity over Indian health that remains today. Although the subsequent Indian Act (1876) included a health-related provision, the language of this provisionⁱⁱ failed to provide clear legislative authority for Indian health to the federal government. A Supreme Court ruling in 1939 confirmed the federal government's legal responsibility for the Inuit (Bonsteel & Anderson, 2006), but did not address health.

The federal government's role in the provision of health services is primarily through the limited public health and prevention services offered by the First Nations and Inuit Health Branch (FNIHB). Services are offered to status (registered) Indiansⁱⁱⁱ living on-reserve and to Inuit living in their traditional territories (Health Canada, 2003a; 2008). The Branch provides non-insured health benefits (NIHB) such as prescription drugs, dental and vision coverage to all status/registered Indians and Inuit,

regardless of where they live;^{iv} however, non-insured health benefits are not offered to Métis. Physician and hospital care is provided by provincial and territorial governments (Health Canada, 2008). Thus, for First Nations peoples living on-reserve, health care is predominately the federal government's responsibility; other Aboriginal groups, with very few exceptions, fall under the purview of the provincial or territorial governments.

As a result of historical legislative vagueness, and the multiplicity of authorities that resulted, the Aboriginal legislation and health policy framework is very complex, resulting in a great deal of diversity in health service provision across provinces and territories. The framework fails to adequately address the health care needs of the Métis or First Nations and Inuit people who are either not registered or not living on reserve/traditional territory (UNICEF Canada, 2009), and has also resulted in much jurisdictional debating about who should pay for health services in particular contexts. For Canada's Aboriginal peoples, these jurisdictional debates add to this

Jordan's Story

Jordan River Anderson, a young child from Manitoba's Norway House Cree Nation, was born in 1999 with a rare neuromuscular disorder, requiring him to receive care from multiple service providers. He spent his entire short life living in an institutional hospital setting, not for medical reasons but because of a jurisdictional dispute between federal and provincial governments and departments over who should pay for his home care. Frustration over these types of jurisdictional disputes have so enraged Aboriginal leaders and children's advocates that a Private Member's Motion (M-296) was introduced in the House of Commons. More commonly referred to as 'Jordan's Principle', the motion stipulates "that in the event of a jurisdictional dispute over funding for a First Nation child, the government of first contact will pay for services and seek cost-sharing later" (Lett, 2008, p.1256). Despite consensus being reached on Jordan's Principle in the House and its endorsement by several provinces, no real progress has been made on implementing it.



ⁱⁱ Section 73 reads: *The Superintendent-General in cases where sick, or disabled, or aged and destitute persons are not provided for by the band of Indians in which they are members, may furnish sufficient aid from the funds of the band for the relief of such sick, disabled, aged or destitute persons* (Venne, 1981, p.43, emphasis added).

ⁱⁱⁱ Registered or status Indian refers to those who reported they were registered under the Indian Act of Canada (Statistics Canada, Definitions, <http://www12.statcan.ca/english/census01/products/analytic/companion/abor/definitions.cfm>).

^{iv} The NIHB program covers people for crisis intervention and mental health counseling, certain medical supplies and equipment, drugs, dental care, vision care, and medical transportation (see First Nations and Inuit Health: Benefits, Ottawa, ON: FNIHB, http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html)

complexity and negatively impact access to appropriate and responsive health care (Hawthorne, 1966; Romanow, 2002).

Transformation of the Aboriginal Health Legislation and Policy Environment

The past forty years have seen a transformation in the provision of Aboriginal health services and programs to increase and enhance the involvement of First Nations and Inuit peoples in the control and delivery of community-based health services. It is now widely acknowledged that Aboriginal communities themselves are better positioned to identify their own health priorities and to manage and deliver healthcare in their communities (Wigmore & Conn, 2003; Lavoie et al., 2005, 2010).

Health Transfer

The movement towards transfer of control began with the federal government's 1979 Indian Health Policy, which recognized that First Nations and Inuit could assume responsibility for administering any or all of their community health programs. It culminated in the development of a Health Transfer Policy framework in 1989, which provided an opportunity for Aboriginal communities south of the 60th parallel to assume control of resources for community-based health programs at their own pace (Wigmore & Conn, 2003). Today, most First Nations communities design and implement their community health programs and employ the majority of their health services staff. Benefits of the health transfer policy have included increased community awareness of health issues, more culturally sensitive health care delivery, improved employment opportunities for community members, a sense of empowerment and self-determination, and an improvement in the community's health status (Lavoie et al., 2005; 2010).

Integrated Agreements

For communities deemed too small to successfully transfer control over health, an integrated model was established in 1994 as a mechanism for broadening opportunities for community control. Provisions and criteria for eligibility differ somewhat from the health transfer model. In addition to communities south of the 60th parallel, communities in the Yukon and Northwest Territories are also eligible. As of 2003, 176 communities have signed an integrated agreement (Health Canada, 2003b).

Policies and Legislation in the Provinces and Territories

At the territorial and provincial levels, some legislation contains specific provisions clarifying the responsibilities of the governments of these territories and provinces in Aboriginal health. These are, however, quite limited and focused on jurisdiction. For example, legislation in Alberta is said to apply to Métis settlements. Alberta, Saskatchewan, Ontario and New Brunswick legislation specifically state that the Minister responsible for health 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 are outside of the province's mandate.

Self-government agreements, where they exist, define areas of jurisdiction for the federal, provincial/territorial and Aboriginal governments. This is reflected in legislation. Health legislation in the Yukon, Quebec and Newfoundland & Labrador contain provisions related to existing self-government agreements, thereby clarifying these territory/provinces' roles and responsibilities in health only in the areas included in these self-government agreements.

Finally, some provinces and territories have embedded provisions related to Aboriginal healing and ceremonial practices. The

Yukon is the only jurisdiction where health legislation recognizes the need to respect traditional healing practices. The legislation does not define what is included as traditional healing practices. Ontario and Manitoba recognize that Aboriginal midwives should be exempted from control specified under the Code of Professions. Ontario extends this exemption to traditional healers. In addition, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick and Prince Edward Island have adopted tobacco control legislation that clearly states that the use of tobacco for ceremonial purposes will not be regulated under the terms of this legislation.

There also exists a limited number of Aboriginal-specific legislation and policies. 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 (Government of Ontario, 1994). 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 Aboriginal health policy currently in place in Canada.

Decentralization/Regionalization of Health Services

Most provinces have opted to transfer the authority over priority setting, planning and delivery of health services to regional health authorities.^v The purpose of decentralizing health care systems has been in part to increase public participation in decision making, set priorities regionally, and coordinate and integrate healthcare

^v The exceptions to this are Prince Edward Island which has chosen to re-consolidate authority for health care to the provincial government (Yalnizyan, 2006) and Alberta that followed in 2008.

delivery (Kouri, 2002; Saltman et al., 2007; Yalnizyan, 2006). However, Ontario is the only province to currently require a council composed of Aboriginal peoples to advise on regional priority setting in healthcare (Lavoie et al., forthcoming; Government of Ontario, 2006).

Emerging Models

Several coordination mechanisms have emerged to bridge jurisdictional gaps and to enhance Aboriginal participation in identifying health priorities, designing strategies, and coordinating approaches to improve Aboriginal health. Generally, these fall into two broad areas: cross-jurisdictional coordination models and intergovernmental health authorities.

Cross-Jurisdictional Mechanisms

Across the provinces and territories, there are several Aboriginal specific health policy-frameworks that provide for cross-jurisdictional coordination mechanisms with the hope of bridging jurisdictional gaps. The frameworks are typically committee-based and bring together stakeholders in Aboriginal health such as Aboriginal organizations and federal and provincial government departments. The most comprehensive example is Ontario's Aboriginal Health and Wellness Strategy (AHWS), which was developed in 1994. The AHWS is managed by a Joint Management Committee consisting of two representatives from each of the eight Aboriginal umbrella organizations in Ontario, as well as several government Ministries and departments (Aboriginal Healing and Wellness Strategy, 2007).

Another example is British Columbia's Tripartite First Nations policy framework which is made up of the Transformative Change Accord and the First Nations Health Plan (TCA – FNHP) and provides for a new governance structure for First Nations health services in BC (FN Leadership Council et al., 2007). A similar framework was developed in Nova Scotia

in 2005 which focuses on the specific needs of the Mi'kmaq (Mi'kmaq et al., 2005). Both of these frameworks, however, address only the needs of the First Nations population, not other Aboriginal groups living within those provinces. Other examples of cross-jurisdictional mechanisms include the Saskatchewan Northern Health Strategy (Northern Health Strategy, 2008), and the Manitoba Inter-Governmental Committee on First Nations Health (Assembly of Manitoba Chiefs, 2010).

Intergovernmental Health Authorities

Intergovernmental health authorities are formal organizations created either through federal-provincial partnerships or self-government agreements. Examples of this are the unique health care structures that emerged as a result of the James Bay and Northern Quebec Agreement. These structures are extensions of the provincial health care system but are co-funded by the federal and provincial governments to serve the health care needs of Nunavik Inuit and the James Bay Cree.

The Athabasca Health Authority (AHA), established in Saskatchewan in 1995, is another example of an Aboriginal health authority that is federally and provincially funded. Like the James Bay and Northern Quebec Agreement, the AHA has a funding agreement with both the provincial and federal governments for the provision of health services for four Métis communities in the Athabasca Basin area: Campbell Portage, Stony Rapids, Wollaston Lake Uranium City, and the First Nations communities of Fond du Lac and Black Lake (Athabasca Health Authority, 2006).

Another example is the Northern Intertribal Health Authority (NITHA), a partnership of the Meadow Lake Tribal Council, the Lac LaRonge First Nations, the Peter Ballantyne Cree Nation, and the Prince Albert Grand Council collectively representing nearly half of First Nations

in Saskatchewan (NITHA, 2010). This makes NITHA the only First Nations health organization of its kind in the country. NITHA provides education and technical support to NITHA partners in the areas of communicable disease control, epidemiology and health status monitoring. NITHA is funded through a contribution agreement with FNIHB.

Modern Treaties and Self-Government Activities

Modern treaties and the granting of self-government status are other mechanisms by which opportunities are being created for Aboriginal engagement in health policy and service delivery. These agreements have their own geographical boundaries that may or may not coincide with the boundaries of provincial health authorities. For example, the Nunavut Land Claims Settlement Agreement (1993) resulted in the creation of the territory of Nunavut, while in the Inuvialuit and Nunatsiag regions, Inuit have signed self-government agreements. In Nunavik, health care structures that emerged as a result of the James Bay and Northern Quebec Agreement (1975) are somewhat unique in Canada: they are co-funded by both federal and provincial governments, managed by Aboriginal authorities, yet also linked to the provincial health care system (Canada, 1974). 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 (INAC, 2007).

In Alberta, the Métis Settlements Accord (1990), which replaced the 1938 Métis Betterment Act, includes a number of health-specific provisions, including the right to: a) make bylaws to promote the health, safety and welfare of the residents



of the settlement area; b) invest money in a hospital district or health region under the Regional Health Authorities; and c) make bylaws respecting and controlling the health of the residents of the settlement area and against the spread of diseases. Since then, the Métis of Alberta have focused on securing increased control over issues such as housing, child welfare, health and legal institutions (MNC, 2007).

Conclusion

There have been many changes in health legislation and policy over the past forty years as it pertains to Aboriginal peoples, including efforts to have Aboriginal-specific provisions in legislation; the development of Aboriginal-specific policies; the inclusion of Aboriginal peoples in the design and implementation of health programs, policies and services; and the establishment of collaborative processes to bridge jurisdictional gaps and provide some coherence to Canada's complex health care system. Yet while there

has been corresponding improvements in the health of Canada's Aboriginal peoples, significant inequities remain in terms of overall health status and access to health services. There continues to be significant gaps in service and jurisdictional ambiguities, directly impacting the health of Aboriginal peoples. Greater coordination is needed to overcome these gaps and ambiguities, and to ensure more equitable funding for and access to health services. In addition, the focus of resources must be on enhancing the health of communities through addressing various social determinants of health, rather than merely dealing with diseases (Chenier, 2002). In order to be successful, such a change must find its way into the federal, provincial and territorial health legislation and policy frameworks. To do so, the adoption of a national umbrella Aboriginal health policy may be required.

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