

On-Reserve First Nations and Health Transfer Policy

Ivana Spasovska

The Canadian facade of multiculturalism and universal health care has been an effective marketing tool in promoting the Canadian national identity. However, does Canadian health care equally serve Canada's population in its entirety? And is it equally accessible to all? In answering these questions, this essay will focus on Canada's on-reserve First Nations communities—with a focus on the province of Manitoba—and argue that the current health care policy, more specifically the Health Transfer Policy, is not sufficient in addressing the culturally-specific health needs and limits the autonomy in regulating and accordingly distributing health care funds, along with providing limited funding over all to the First Nations peoples. The issue is that Canadian First Nations communities receive below average health care services even though their substandard health has been increasingly rising in comparison to the Canadian non-Aboriginal population (Larson, 2011). In exploring the issues relating to health care policies of First Nations communities, this essay will explain the historic background of the issue and its importance to the well-being of these communities, and will then examine the issues regarding the Health Transfer Policy—public surveillance, provincial cost-shifting, and impacts on personal home care (PHC)—and lastly I will also consider the issues of the federal government's neglect of cultural-specific needs in relation to health care access. A general consensus can be made in stating that Canadian Aboriginal communities are currently lacking the autonomy and self-governance that would better allow them to resolve their socio-economic and health issues. This of course can be achieved through more effective tripartite communication—between federal, provincial and municipal governments—and through incorporating Aboriginal communities in research procedures and effective policy-making.

The issues concerning health status of First Nations communities do not solely depend on federal health care funding and are not clear-cut; there is a grey matter that involves socio-economic disparities, cultural barriers, unemployment, housing, education, and so on, between Aboriginal Canadians and non-Aboriginal Canadians (Newbold, 1998). Although these issues will not be discussed throughout this essay, it is important to note their relevance and that Aboriginal Canadians are faced with a magnitude of multi-dimensional issues. In terms of health care disparities, First Nations communities have been, and still are, receiving health services from the federal government (MacIntosh, 2008). MacIntosh explains that Aboriginal Canadians

who are entitled to receive these health services are the Inuit and those who have Indian status under the Indian Act (2008). As such, the First Nations and Inuit Health Branch (FNIHB) is a division of Health Canada that specifically addresses the health status of the aforementioned communities (MacIntosh, 2008). First Nations peoples are increasingly showing poor health status and are in fact undermined by federal and provincial governments in comparison to other non-Aboriginal Canadians.

To address such concerns, the Indian Health policy was passed by the federal government in September 1979, which aimed at placing greater responsibility on Indian communities in efforts to improve their health status (MacIntosh, 2008). Through the Indian Health Policy the federal government outlined three main areas for improvement that would guarantee increased health services: the first area of improvement would focus on socio-economic, cultural and spiritual development; the second area would aim to improve the relationship between the federal government and Aboriginal peoples; and the third area would deal with the federal government's role in "Canadian health system as it affects Indians" (MacIntosh, 2008). Subsequently, by 1989 the federal government had also passed the Health Transfer Policy to deal with health inequalities between Aboriginal Peoples and the rest of Canada (MacIntosh, 2008).

The Health Transfer Policy contains three types of contribution agreements through which First Nations communities can engage in "priority setting, program planning and service delivery" (Lavoie, Forget, Prakash, Dahl, Martens & O'Neil, 2010). These consolidated contribution agreements are as follows: the general agreement, the transfer/target agreement, and the integrated agreement (Lavoie et al., 2010; MacIntosh, 2008). The general agreement is usually limited to a one year term of delivering services in which First Nations peoples have no authority in deciding where to distribute funding in accordance to growing community needs (Lavoie et al., 2010; MacIntosh, 2008). The integrated agreement provides communities with some flexibility in establishing their own health management structure but the task of delivering services is still shared with the FNIHB (Lavoie et al., 2010). Lavoie also explains that under this agreement, "community funding is based on historical expenditures" (2010), meaning communities cannot create new programs, however, they can "make some program adjustments to reallocate resources and to set up health management structures that receive funding on an on-going basis" (Lavoie et al., 2010). And lastly, the transfer/target agreement can be signed on a

three to five year term and it “includes the transfer of knowledge, capacity and funds” which allows for greater community autonomy to distribute health resources in accordance to community needs and priorities (Lavoie et al., 2010). Even though this agreement requires the allocation of resources towards immunization, communicable disease control and environmental/occupational health and safety, it is more desirable because sufficient funding will be left over to plan new programs and focus resources on high priority services (MacIntosh 2008).

In examining some of the current challenges faced by First Nations communities, it seems that there is lack of inter-governmental co-ordination and communication. The health status of First Nations communities is compromised in part because public health surveillance seems to be lacking communication along all levels of governance. Under the Health Transfer Policy, the transfer/target agreement would help to establish a more cohesive inter-governmental relationship in the long run, and would in turn create better avenues of effectively communicating information. Public surveillance is an important process that collects, interprets, and analyzes outcome-specific data, “which is used for planning, implementing and evaluating public health practices” (MacIntosh, 2008). Unfortunately, there seem to be gaps among jurisdictions when reporting on public health.

Referencing a 2005 study on First Nations health transfer program in Manitoba conducted by Lavoie, MacIntosh supports her claim that apparent breaks in jurisdictional communication between provincial public health authorities and on-reserve health centres leaves communities and Band members uninformed and ill-prepared to handle communicable disease control (CDC) cases (MacIntosh, 2008). Under the transfer/target agreement, even though First Nations assume responsibility of addressing issues with CDC they do not have a clear relationship with the provinces since the transfer agreement does not clearly outline the provincial role. In the case of Manitoba, “Manitoba Health notifies the FNIHB of any CDC cases, FNIHB notifies its regional office, and the regional office contacts the on-reserve caregiver” (MacIntosh, 2008). Although this form of intergovernmental communication allows the on reserve caregiver to address the infected patient, the process does not necessarily include First Nations on-reserve health programming authorities in the process, which limits their ability to effectively manage health programs. The increasing need to strengthen co-operation and

communication between federal-provincial-municipal lines is apparent when dealing with health care policy. Weak public surveillance will only hinder First Nations communities' health status through ineffective and indirect communication of information.

Intergovernmental relations may directly affect population well-being and growth, much like that of the First Nations. Having limited self-governance and limited health care funding, First Nations communities are sensitive to provinces' health care program management. Whenever provinces decide to employ less expensive means of implementing health services, they usually redirect service costs through closing of hospitals, reduction in available hospital beds and reduced hospital stay, which generally means that First Nations on-reserve health care facilities are burdened with delivering services on a tight budget (Lavoie et al., 2010). First Nations that have entered the transfer/target agreement are subject to a non-enrichment clause, which means that service funds are determined upon signing of the agreement, and are calculated based on delivery costs per on-reserve status Indian (Lavoie et al., 2010; MacIntosh, 2008). Being faced with provincial cost-shifting, the non-enrichment clause does not provide funds re-negotiations—throughout the agreement term and upon renewal of transfer agreement—and caps funding regardless of growing population needs of on-reserve First Nations (Lavoie et al., 2010; MacIntosh, 2008). Federal funding and provincial cost-shifting are irrespective of the growing need for First Nations community health nurses, home care, and increased coverage for travel to near-by hospital facilities (Roscelli, 2005).

Such provincial health care cost-shifting has had a significant impact on the aging population of First Nations in Manitoba, as personal care homes (PCH) are in need of better funding and are in demand due to the communities' poor health status. Unfortunately, First Nations communities are running their PCHs at a deficit level mainly due to the funding cap under the Health Transfer (Roscelli, 2005). Through the Health Transfer Policy federal and provincial governments simply do not provide sufficient funding to First Nations to address increasing costs of living and increasing health services. Roscelli notes that historically First Nations communities and on-reserve PCHs have not had direct access to Manitoba's provincial funding due to jurisdictional limitations; First Nations reserve lands are under federal lands jurisdiction, thus limiting provincial jurisdiction (2005). In this care, the lack of intergovernmental co-operation has left jurisdictional issues between federal-provincial and First

Nations unresolved. A proposed provincial licensing of PCHs would potentially improve health standards as First Nations would have access to provincial health funding, however, First Nations have been reluctant to undergo such change due to restricted re-direction of funding. If First Nations were to have their requests for their own jurisdiction recognized, they could set appropriate standards that would address their own “culturally-based responsibilities and rights” (Roscelli, 2005).

Undeniably, if First Nations had jurisdictional control, there would be an increase in primary health care services within the communities. With provincial health care cost-shifting and reduction of on-reserve health facilities increasing, community members are forced to seek health services from nearby provincial health practitioners; however, the underlying problem with this arrangement is that most First Nations communities have limited or no transportation to nearby provincial health services in addition to having limited federal subsidy for transportation (Webster, 2009). What is more, many First Nations individuals prefer the care of on-reserve medical practitioners primarily because it is easier to identify with them based on cultural competence and understanding (Bearskin, 2011). The ways in which First Nations peoples view and practice medicine is different than that of non-Aboriginal communities; they place great importance on the environment, the body-soul dynamic, engagement between mutual understanding of patient and practitioner, and mutual respect for one another (Bearskin, 2011). For now, the transfer/target agreement allows those First Nations under the agreement to redistribute their health resources based on community needs, and as such can sustain on-reserve practitioners and nurses that will meet the culturally-based health concerns.

In closing, evidence from empirical data shows that there needs to be an improvement in intergovernmental co-operation and inclusion of Aboriginal Canadian communities in policy-making processes. Currently, there is an apparent lack of harmonized federal and provincial policies which have directly resulted in weakened on-reserve First Nations health care services. As Webster has noted, “federal reluctance to invest in local nursing stations within First Nations communities impairs health outcomes and inflates costs to provincial health budgets” (2009). Through transferring control of health care services to First Nations, the communities would reap greater benefits with faster and efficient care, despite concerns of “financial constraints imposed by the federal government” (Webster, 2009). Policy and program change will occur only with

the full involvement of First Nations representatives in federal and provincial discussions to clarify jurisdictional issues. As Roscelli notes, it is important for First Nations to set their own jurisdiction and apply certain set of standards that outline their “culturally-based responsibilities and rights” (2005). Improvements in First Nations health status may be seen when there is a shift from a unilateral federal decision-making government to a more multilevel inclusive government that involves Aboriginal Canadian communities within the policy-making process that ultimately affects their well-being. Transferring control to Aboriginal Canadians enables them to effectively redistribute sources and develop new programs to address issues not only concerning health status, but also the socio-economic disparities which are currently impairing the community’s well-being.

Bibliography

- Bearskin, Lisa Bourque. "A Critical Lens on Culture in Nursing Practice." *Nursing Ethics* 18, no. 4 (2011): 548–559.
- Larson, Bonnie, Herx, Leonie, Williamson, Tyler, & Crowshoe, Lynden. "Beyond the Barriers: Family Medicine Residents' Attitudes Towards Providing Aboriginal Health Care." *Medical Education* 45, no. 4 (2011): 400-406.
- Lavoie, Jose. Forget, Evelyn. Prakash, Tara. et al. "Have Investments in On-reserve Health Services and Initiatives Promoting Community Control Improved First Nations' Health in Manitoba?" *Social Science & Medicine* 71, no. 4 (2010): 717-724.
- Newbold, Bruce. "Problems in Search of Solutions: Health and Canadian Aboriginals." *Journal of Community Health* 23, no. 1 (1998): 59-73.
- MacIntosh, Cameron. "Envisioning the future of aboriginal health under the health transfer process." *Health Law Journal*, Special Ed. (2008): 67-100.
- Roscelli, Margaret. "Political advocacy and research both needed to address federal-provincial gaps in service: Manitoba first nations personal care homes." *Canadian Journal of Public Health* 96 (2005): 55-59.
- Webster, Paul. "Local control over aboriginal health care improves outcome, study indicates." *Canadian Medical Association Journal* 181, no.11 (2009): 249-50.

Third Year Essay

Citation Style: MLA