A Patchwork of Inequity:
thirteen decades of organizational development of First Nation health organizations in Saskatchewan 1876-2006

A historical background paper based on a literature review prepared by the Capacity Development Working Group, First Nations and Inuit Health Branch, Saskatchewan Region
Original draft by Larry Sanders, with input from members of the Working Group June-July 2006

The viewpoints expressed in this paper are those of the various authors quoted and the members of the Capacity Development Working Group and do not necessarily reflect the official views of the Government of Canada

Please address any inquiries concerning this paper to:
Larry Sanders
Chair, Capacity Development Working Group
First Nations and Inuit Health Branch
Health Canada
18th floor, 1920 Broad Street
Regina, SK S4P 3V2
Phone (306) 780-8683
Fax (306) 780-7733
Cell (306) 527-6037
e-mail: larry_sanders@hc-sc.gc.ca

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Synopsis: chronology of events, studies and reports covered in this paper

Date	Event
1876	Signing of Treaty Six
1966-67	Hawthorn studies on "Indians of Canada" paint dismal picture of First Nations life
1969	White Paper on Indian Policy tabled by Jean Chrétien
1975	James Bay and Northern Quebec agreement
1978-79	WHO Alma-Alta Declaration redefines the meaning of "health"
Jan. 22, 1979	11 year old First Nation girl dies in hospital in Alert Bay, B.C. from an appendicitis attack, sparking public inquiry
Sept. 19, 1979	Federal Indian Health Policy announced
1979-80	Battleford Tribal Council multi-band health services agreement replaces former federal Indian hospital
1980	Thomas Berger report on Indian and Inuit health funding and agreement system
May 1980	Alert Bay inquiry report released, slamming racist and negligent care of First Nations
1982	Canadian Charter of Rights and Freedoms adopted which includes Section 35, recognizing and affirming "existing aboriginal and treaty rights"
1982	Community Health Demonstration Program (CHDP) launched
1983	Penner Report on Indian Self-Government released
Jan. 18-21, 1988	5 members of Sandy Lake First Nation stage hunger strike at Sioux Lookout Zone Hospital in Ontario protesting poor health services and get a public inquiry
March 16, 1988	Federal cabinet approves the health transfer policy framework
Sept. 22, 1988	Montreal Lake First Nation signs first transfer agreement
May 1989	The panel set up because of the Sioux Lookout hunger strike releases the final report of its inquiry. The report[1] stops short of the recommendations for self-government in health advocated by the hunger strikers and the Nishnawbe-Aski Nation.
June 29, 1989	Treasury Board approves spending authorities for Transfer initiative
1990-91	Meadow Lake Tribal Council signs multi-band health agreement
1990s	Transfer agreements signed in multiple locations and tribal councils
September 1996	Auditor General Report on Canada/First Nations relations
Nov. 21, 1996	Final report of the Royal Commission on Aboriginal Peoples (RCAP)
Oct. 1997	Auditor General review of FNIHB
1998	Battleford Tribal Council successfully completes CCHSA[2] accreditation
Sept. 28, 1999	Adams report on Meadow Lake Tribal Council/FNIHB dispute
Oct. 2000	Auditor General review of FNIHB
Oct. 2000	FNIHB orders forensic audit of Fontaine treatment centre in Manitoba
April 11, 2001	Fyke report on Saskatchewan health care system released
March 2002	Western First Nations object to new agreement template of FNIHB
November 2002	Romanow report on national health care system released
November 2002	FSIN, province and federal governments release joint paper on treaty right to health
December 2002	Auditor General report on paperwork burdens of First Nations
Feb. 2003	Cost study of Saskatoon Tribal Council released
Feb. 5, 2003	First Ministers' Accord on funding health care
Jan. 30, 2004	Forensic audit of Fontaine centre released
April 19, 2004	First Canada-Aboriginal Peoples Roundtable (CAPR) session held in Ottawa
Sept. 13, 2004	First Ministers and NAOs launch Health Blueprint process
Nov. 4-5, 2004	CAPR health sector follow-up session in Ottawa
Nov. 23, 2004	Another study of MLTC financial issues released

[1] titled *From Here to There: Steps Along the Way — Achieving Health for All in the Sioux Lookout Zone*, by Archbishop Ted Scott, Wally McKay and Dr. Harry Bain.

[2] Canadian Council on Health Services Accreditation

Jan. 25-26, 2005	CAPR follow up session on "accountability for results"
Feb. 23, 2005	Federal budget includes $700 million for aboriginal health
March 2005	National evaluation of transfer system released
March 2005	FSIN Health Summit, Saskatoon
April 1, 2005	Treasury Board authorities for FNIHB transfer initiative renewed
June 24, 2005	Capacity Development Strategy, FNIHB Saskatchewan, released
Nov. 18, 2005	McArthur report on Saskatchewan training system released
Nov. 24-25, 2005	Kelowna, B.C. First Ministers meeting with aboriginal leaders announces $5.1 billion to eradicate aboriginal poverty and improve health
Dec. 14, 2005	Saskatchewan's Health Workforce Action Plan released
May 16, 2006	Auditor General report audits federal performance on previous reports

[For First Nation health organizations] "the current funding formula is not sufficient to maintain a sustainable system."

"The overall picture is that of a patchwork, not a system. The administrative cost of maintaining this patchwork of agreements, with their periodic amendments, is considerable."

— Josée G. Lavoie et al, Centre for Aboriginal Health Research, March 2005. *Evaluation of the First Nations and Inuit Health Transfer Policy.* Volume 1, pages 19 and 24.

"The story of federal-provincial fiscal relations is one of a renewed style of partnership and equality between governments; public policy initiatives arising from either order of government; federal block transfers with fewer conditions than before. . .

By comparison, for many long years, the story of federal-Aboriginal fiscal relations is of a rhetoric of partnerships, yet a reality of a hierarchical relationship with the supremacy of Ottawa; reform ideas continuing to come mainly from within the federal government with charges of little or no consultation with Aboriginal governments and peoples; federal transfer payments which are highly conditional and regulated; significant asymmetry in funding arrangements and opportunities among First Nations, Inuit, Métis and non-Status Indians; . . . and ongoing tensions and issues of mutual trust and respect."

— Michael J. Prince and Frances Abele, November 2002. *Paying for self-determination: aboriginal peoples, self-government, and fiscal relations in Canada*. Paper presented at "Reconfiguring Aboriginal-State Relations, Canada: The State of the Federation, 2003" conference at the Institute of Intergovernmental Relations, School of Policy Studies, Queen's University

Introduction

This document was prepared as a follow-up to input that was received by FNIHB from members of the Capacity Development Working Group (CDWG). The CDWG consists of representatives from First Nation health organizations at the local and tribal council levels, as well as staff from FNIHB. CDWG was initially asked in December 2004 to come up with a capacity development strategy for the region, a task which was completed in June 2005 with the tabling of *Building on Strength: a proposed regional capacity development strategy 2005-2015*.[1] In the fall of 2005 the Regional Director asked the CDWG to begin work on AHHRI, the Aboriginal Health Human Resource Initiative. AHHRI was announced in the federal budget of February 2005, and the expectation at that time was that funds under the initiative would be rolled out beginning in late 2005, or at the latest in the early part of the new fiscal year beginning April 1, 2006. As a result, Saskatchewan Region commissioned an environmental scan from the Indigenous Peoples' Health Research Centre (IPHRC) to examine aboriginal health human resource challenges facing First Nation health organizations in Saskatchewan. That environmental scan was delayed for reasons which are explained in the IPHRC report, which was completed in June 2006 and is being tabled separately. AHHRI itself was delayed by the federal election and the change in government, but is now proceeding to fund initiatives, based on the regional plans and environmental scans.

The members of the CDWG have concluded that successful capacity development and health human resources strategies must address the wider context — what is known about *why* we are in the situation we are with human resource management issues in First Nation health organizations. The IPHRC environmental scan addresses the current realities in aboriginal health human resources, but not the history of how we got to this point. That is the purpose of this document. First Nation representatives on the CDWG have repeatedly noted to the FNIHB members of the working group that AHHRI at best could lead to incremental changes, not substantive structural improvement in First Nation health organizations. AHHRI was not designed or intended to address such structural issues. By standing back and looking at the policy history as this paper does, it is evident that thirteen decades of federal government policies dating back to Treaty Six in 1876 have not been able to address the challenges faced by First Nation health organizations. AHHRI can not, and was not intended to, fix this historic problem. Nonetheless, the Working Group members wish to convey to federal officials in loud, clear language the history of the relationship between the First Nation health organizations and the federal and (and sometimes provincial) governments. Whether some other initiatives (other than AHHRI) address these inequities remains to be seen. By at least understanding the historical context and how the inequities came to be, we can make wiser investments through AHHRI in projects and strategies which support the positive trends evident in our history, and start to reverse the negative effects of past policies.

This document builds on the historical literature review which was completed as part of the Capacity Development consultations and report in June 2005. Since then other reports and studies have been brought to the attention of the Working Group. Many of these are reports and studies which were commissioned over the years by First Nation health organizations, tabled with FNIHB, then largely ignored. We have relied as much as possible on independent reports and studies by academics and commissions of inquiry, because when you see FNIHB's history through such eyes, you see a pattern.

We title this report a "patchwork of inequity" because our historical review has found that the First Nation health system at this, the start of the twenty-first century, is not a "system" at all, but a

patchwork. But even patchwork quilts are woven together, and what holds this quilt together is an historical pattern of what many refer to as inequitable treatment.

The most glaring example of such inequity arises from the limitations of federal funding policies: the nature of scope of the funding authorities within the federal government are such that Health Canada has not been able to provide sufficient funding to First Nations to ensure that staff employed by First Nation health organizations receive equal pay to what those same jobs would pay if they were in the federal government, or elsewhere in the health system AHHRI, which has the stated purpose of addressing "recruiting and retention" issues in First Nations and Inuit health, is not designed to or able to address that inequity.

Despite this severe limitation to what AHHRI can address, several First Nation health organizations and members of the working group want to make the best use possible of what funds are available from AHHRI, all the while recognizing that the systemic inequities need to be addressed. This "take it and make the best of it" attitude has prevailed in Saskatchewan Region FNIHB for decades, as our earlier *Building on Strength* report documented. Despite the limitations of the Transfer initiative and other funding and program policies of FNIHB, First Nations in Saskatchewan have built innovative, community based clinics, hospitals and population health programs to address some of the needs of the 76 First Nations in the region. The people employed by these First Nation health organizations face enormous human resource challenges, but nonetheless have carried on through suicide epidemics, chronic diseases resulting from poor socio-economic conditions, and seemingly "one crisis after another" at the community level.

The purpose of this document is to recognize those people by sending a clear message to federal officials from the Working Group that until the present patchwork becomes a quilt of equality and partnership as envisioned in the original Treaties, First Nation health organizations will continue to, at best, be only able to make incremental improvements in the lives of their communities, and their own organizational development. Over 13 decades, stacking one generation of incremental change on top of another has led to some progress and improvement. This report notes some of the achievements of First Nation health organizations in Saskatchewan that have come about though such "one step at a time" approaches. But we can do much better if we have a clear understanding of what has come before us and how our actions today will or will not correct past inequities.

Historical Context: themes in the patchwork - 1876-2006

When you stand at the top of a tall building and look down on the traffic moving in and around a city below, patterns eventually become clear. This document takes a similar approach. We are looking at history not too far removed from ground level, but from a high enough vantage point that we can see patterns and trends. We encourage you to read through the historical details, and look up the references we cite, so you can see the finer points as we have.

To prepare this historical review, several different types of documents and reports were used, including:

- books and articles published by academics
- reports of commissions, task forces, and consultants
- reports and position papers tabled by First Nation organizations as well as provincial and federal governments

In all cases we have tried to "read between the lines" and measure the rhetoric of what is said against the realities of what is actually done, particularly by governments. The patterns we see as we read all this material can be summarized under the following five themes:

(1) A treaty right vs. a policy approach to health
(2) More reporting does not necessarily achieve greater accountability
(3) Language of self-government vs. cost containment
(4) First Nation accountability vs. reciprocal accountability by the federal government
(5) Incremental steps towards self-government

We encourage readers to go through the details of the historical review which follows. As you read through all the history as we have, we ask you to keep the following five themes in mind.

(1) A treaty right vs. a policy approach to health:

First Nations and the federal government appear to have different understandings of what was meant in 1876 by the "medicine chest clause" of Treaty Six. First Nations believe the Treaty was a commitment by the Queen to enable First Nations health to be managed as they had become used to looking after themselves: in a community-controlled, holistic manner. The federal government has seen the Treaty as a commitment to keep medicines locked up in a box, handed out at the discretion of the keepers of the keys. This policy disagreement has never been resolved, either by court rulings, or by substantive realignment in federal and provincial health policies so a "treaty right to health" is given a new, modern meaning in keeping with the original intent. The Government of Canada, the Province of Saskatchewan and the Federation of Saskatchewan Indian Nations were able to make some progress on this issue, releasing a discussion paper in 2002[2] outlining the respective parties' understanding of "treaty rights to health" in the modern context and understanding of the treaties, but little progress appears to have been made since then.

(2) More reporting ≠ greater accountability.

Three historical patterns described in this literature review weave together to create a paperwork jungle for First Nations:

- Auditor-General reports noting inadequate reporting on outcomes from FNIHB funding
- a fraud scandal at an aboriginal treatment centre in Manitoba
- a federal response to the first two developments which appears to equate the bureaucratic convenience of standardized "one size fits all" funding agreements and more onerous internal financial procedures and First Nations reporting with accountability.

This jungle neither provides FNIHB with the information it needs to measure performance, nor provide communities with meaningful measures of health outcomes. Have the rates of diabetes, suicide, chronic heart conditions, obesity and substance abuse actually declined because of the investments made by FNIHB and First Nations? Neither side can really tell, because the "system" of legally standardized agreements measures annual outputs of how programs were conducted, not health outcomes. Along the way, capacity of even the smallest First Nation are significantly diminished because staff are filling out volumes of documents which are often not reviewed or assessed by FNIHB, and appear to be used largely to satisfy the FNIHB that a product was

received, not whether any conclusions can be drawn about program quality or impacts on health status through the delivery of those programs.

The view of the CDWG is that accountability can best be achieved by developing sustainable, accountable organizations, not by adding either greater complexity to the paperwork management system or more layers of officials at Health Canada to monitor compliance. The First Nation organizations who have developed accountable health organizations also have demonstrably the best record of "compliance" with FNIHB's reporting requirements.

(3) The language of self-government vs. cost containment

Several academic studies of First Nation health transfer agreements noted in this report have concluded that while Health Canada and FNIHB use terms like "self-government development" as one of the purposes of their agreements with First Nations, the reality of what happens with those contribution agreements is much different than the rhetoric. The academic studies cited in this chronology have concluded that the language might be self-government, but the real agenda is cost containment.[3] This policy is not stated openly, but the nature of the federal system and its funding arrangements results in its being practiced directly in the management of agreements, and as a result experienced directly by First Nations. This operational reality, combined with the policy/treaty disagreement (#1 on this list) puts First Nations in an awkward position. First Nations want to take steps towards self-government, and might even be drawn in by the rhetoric, but they have to use the funding they receive with all the accompanying strings and try to use the situation to achieve their objectives without "breaking the rules" of the funding provided by FNIHB. This is a difficult balancing act, but many First Nation health directors and leaders of health organizations have learned how to walk these lines well, resulting in some incremental steps by First Nations towards understanding the dimensions of self-government and improving their chances of having the capacity to fully achieve that status some day.

(4) First Nations are highly accountable, but reciprocal accountability to First Nations by the federal government is not practiced

Other than Auditor General reports and the RCAP report, there are few historical examples of the federal government being held in even partially accountable for its performance, or lack of performance, in meeting its contractual and fiduciary obligations toward First Nations. Instead, because the federal government collectively gives itself the authority to decide if it has met its own obligations, and accountability is defined by the same people who deliver the policies in question. This conflict of interest is evident in FNIHB's response to challenges, such as the ones made by Meadow Lake Tribal Council or Saskatoon Tribal Council to FNIHB meeting its obligations as a signatory to transfer agreements. The First Nation health organizations are held to high standards of program and financial accountability, and put into third party management or some other fate if they fail to meet their obligations under the signed agreements. But the strong evidence suggests that the federal government gets to decide for itself whether it has met its obligations as a signatory, and rarely if ever concludes that it has not done so.

(5) Incremental steps towards self-government

First Nations have been able to make remarkable progress towards achieving their own objectives in health care. For example, the health services provided by the Battleford Tribal Council have been reviewed by, and passed, standards set by the CCHSA, the Canadian Council on Health

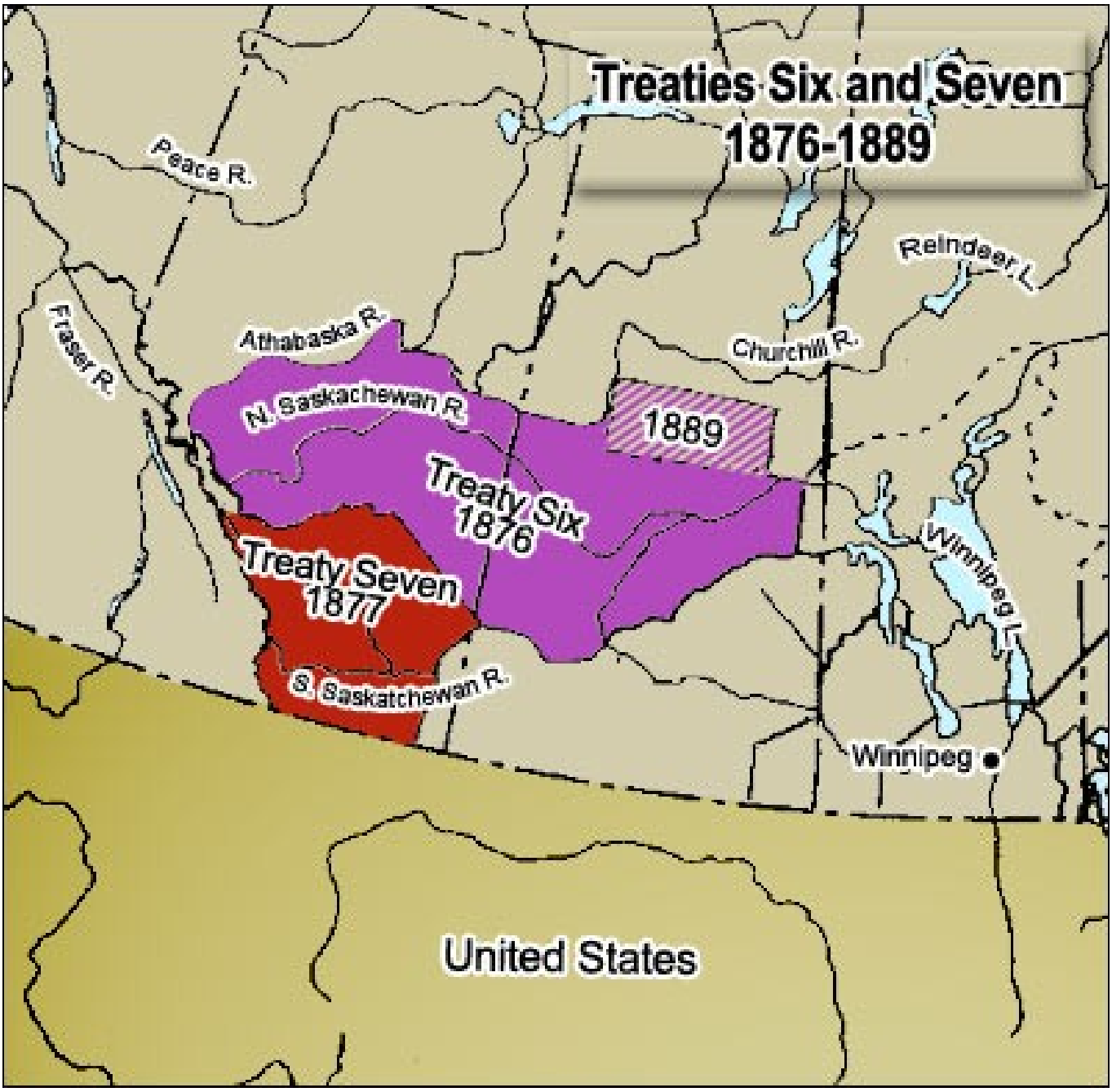
Services Accreditation. Tribal Councils and First Nations across Saskatchewan have entered into innovative partnership agreements with each other and with provincial health authorities and regions to manage joint hospitals, manage community care programs collaboratively, and/or work together to build a representative health work force. There are now strong First Nation organizations planning to take the next step towards being self-governance in health. But not all organizations, communities and tribal council organizations are the same, nor should they be. Some have suffered under the inequities more than others. Some need more development assistance, while some are ready to leave development with their own strategic plans for human resources and capacity development. Our hope by putting this historical review together is that such diversity can cease being a patchwork of inequity and instead become a quilt of self-determination in health.

The federal government needs to be more accountable for its performance, and a First Nations capacity development strategy must:

- c identify the reasons for the failures of the past:
- i support bottom-up approaches that have worked in the past stand the best chance of being successful in the future; and
- s work with First Nations as partners to evolve self-government plans for health delivery with each First Nation, tribal council and health organization.

The closing words of a textbook on aboriginal health in Canada say it best:

> "Ultimately, the best chance for improved health in the Aboriginal population of Canada rests in the continuation and acceleration of the process of self-determination." James B. Waldram et al, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*. University of Toronto Press, 1995. page 271


Treaties Six and Seven
1876-1889
Peace R.
Fraser R.
Athabaska R.
N. Saskachewan R.
1889
Treaty Six
1876
Treaty Seven
1877
S. Saskatchewan R.
Churchill R.
Reindeer L.
Winnipeg L.
Winnipeg
United States

Detailed historical literature review, 1876-2005

1876: Treaty Six[4] is signed covering central Saskatchewan and Alberta and into parts of Manitoba.[5] containing a "medicine chest clause" which reads:

> That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent. That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant... assistance of such character or to such extent as the Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians from the calamity... befallen them.[6]

The Cree who signed Treaty Six thought they would receive protection from the Crown from starvation, and safe refuge in the form of reserves to be established on land of their choosing. But after signing Treaty 6 and in the period leading up to the Riel Rebellion in 1885, the Cree were confronted with deception and coercion. They were pushed off the reserves they had selected in the Cypress Hills, and encouraged to move to the area near the Qu'Appelle Valley. One tactic used by the colonial administrators was denial of food rations unless the bands moved to where the government wanted them to move. The winter of 1884-1885 was particularly hard,[7] resulting in many deaths by starvation.

> The record of the Canadian government in dealing with the Cree is . . . not one of honourable fair-mindedness and justice as the traditional interpretation portrays. . . . [Northwest Territories Commissioner Dewdney] had refused to grant the Cree the reserve sites they selected; he refused to distribute the ammunition and twine the treaties required. His plans for dealing with the Cree leaders were based on a political use of the legal and judicial system, and ultimately he made use of the military, the police and the courts in a political manner to achieve his goals of subjugating the Cree. Only by ignoring these facts can one continue to perpetuate the myth of Canada's just and honourable Indian policy[8] from 1870 to 1885.[9]

Tobias describes the policies put in place by the Government of Canada as "sheer compulsion," because Dewdney believed such practices were "the only effective course" to follow.[10] Dewdney convinced Macdonald to amend the Indian Act (first passed in 1876, the same year as Treaty Six) so he would have the authority to move Indian populations forcibly if they were on land not assigned to them.[11] Thus, through the combined compulsive force of the military, starvation and intimidation, and legitimated by legislation, the Cree were moved to reserves isolated from one another, not close together as they tried to be under Cree Chiefs such as Big Bear and Piapot.

The medicine chest clause was subsequently claimed as a 'treaty right' by other status Indians in Canada,[12] particularly after Supreme Court decisions interpreting the clause meant that the Government of Canada had the sole discretion to define what was going to be provided, that there is not a treaty *right* to unlimited health services.[13]

> As a result of [the Supreme Court] cases, the federal government has been supported in its position to provide medical services to Indians as a matter of policy, rather than legal obligation. ***This effectively allows the government to alter services as it wishes***. Indian organizations, in contrast, remain firmly

> committed to the view that the 'spirit and intent' of the treaties should be honoured, and that the Indian view, as currently evident in the oral tradition, should be accepted as the true version of the promises.[14]

The indigenous tradition of taking into account not just the printed words of the written treaty, but the conversations and presentations made at the time of the signing of the treaty (what Waldram et al 1995 calls 'spirit and intent'),[15] is the cause of an ongoing dispute over the interpretation of the 'medicine chest' clause. The understanding of the Cree is that they were signing a holistic package, agreeing to let the newcomers use the land in exchange for assistance from the crown to establish a new livelihood (farming) as well as protection from famine, disease and encroachments by settlers on to reserve lands the Cree would choose. The 'medicine chest' was just one item in what they understood was a complete package of benefits to be provided by the crown. For its part, the federal government has convinced various courts to agree with its view stressing the literal meaning of the *written* words of the medicine chest clause, denying the interpretation that it could be construed as a promise of free and unlimited medical care. One Saskatchewan Court of Appeal ruling even went so far as to suggest that the clause should be interpreted to mean all that is really required today to uphold the crown's responsibility under Treaty Six would be to give each band a first aid kit.[16]

Within a decade of signing Treaty Six, the Cree were so vexed by the government's failure to abide by their understanding of the Treaty that they demanded redress, and complete fulfillment of the treaty terms by the summer of 1885. They threatened to do whatever was necessary, short of war, to obtain redress.[17] The response to those demands was the policy of "sheer compulsion" from Dewdney, and after the Riel Rebellion and the defeat of the Métis in 1885, the Cree were forced to live where the government decided, and so the Cree retreated. Over time, without rations or assistance in the form of farm implements to grow their own food, the on-reserve populations continued to decline, and diseases became rampant and repetitive, until the middle of twentieth century.[18]

The medicine chest clause has been tested in the courts, with inconclusive results. The federal government argues its interpretation of the clause has been upheld by the courts, but there has not been rulings on the medicine chest clause since the Charter of Rights came into effect in 1982. Section 35 (1) of the Charter has been used by the Courts to provide wider interpretations of, and support for, the concept of "existing aboriginal and treaty rights" supported by the Charter. One legal scholar has called for increased legal imagination, since Canada's approaches to aboriginal rights have to go beyond the courts to include socio-economic and governance reforms:

> Treaty jurisprudence ought to be refashioned so as the conceptualize the purpose of treaties to be protection of particular forms of self-government, and the broad and purposive method of interpretation currently accepted by the judiciary ought to be redirected so as to conform to such a purpose.[19]

But until a new court ruling on the medicine chest clause, the "agreement to disagree" remains between the federal government and First Nations, with the federal government taking the position that they provide health services as a matter of policy, while First Nations take the position that the Treaty imposed on federal government a fiduciary obligation to provide complete health services.

The judge's ruling often cited to support the federal government's position is as follows:

> The clause itself does not give to the Indian an unrestricted right to the use and benefits of the "medicine chest" but such rights as are given are subject to the direction of the Indian agent... I can find nothing historically, or in any dictionary definition, or in any legal pronouncement, that would justify the conclusion that the Indians, in seeking and accepting the crown's obligation to provide a 'medicine chest' had in contemplation provision of all medical services, including hospital care.[20]

The opposing viewpoint is perhaps best summarized by Alma Favel-King, in a discussion paper she prepared for the Royal Commission on Aboriginal Peoples (RCAP) in 1993:

> It is the federal government's view that [the Treaty Six medicine chest] clause refers to the equivalent of a first aid kit. However, it is the view of the First Nations that [the clause] means access and availability of a wide range of primary, secondary and tertiary health services. Testimony from elders indicates that at the time of the negotiation of treaties, the Queen promised her subjects that she would look after them in the manner in which they had looked after themselves. First Nations' holistic concept and understanding of health led to a broad interpretation of this agreement. (Favel-King 1993, page 121)

The Office of the Treaty Commissioner of Saskatchewan's web site takes a somewhat neutral view of the meaning of the "medicine chest clause," saying it was meant to refer to the First Nations desire to receive from the government "the best medical care available."[21]

1939-early 1950s: Historical records indicate that federal officials responsible for recruiting doctors and nurses to treat status Indians on reserve had difficulty because many health care professionals had

> . . . views of Indians as 'dirty' and 'diseased' . . . . and while the existence of disease among these peoples is not contestable, the underlying attitude at the time that the Indians were inferior certainly is.[22]

This dark period in Canadian history includes the establishment of residential schools and other colonial policies which were a logical follow-through to the moral tone of white Christian missionaries of the Canadian west, who portrayed aboriginal populations as "'noble, wretched, and redeemable."[23] Various elders and officials of Tribal Councils in Saskatchewan have repeatedly told FNIHB that negative attitudes towards First Nation peoples on the part of health care professionals was widespread, and long remembered by First Nation people who started dealing with the Medical Services Branch after it was created by the federal government in 1944-45. This period in history (up to the end of the Second World War) has been referred to as a period of the "benign neglect" policy towards First Nations in particular.[24] Other scholars have characterized the period in Canadian history before the 1969 White Paper as being dominated by one policy paradigm, that of internal colonialism:

> [this] policy paradigm . . . has dominated the federal government's relationships with Indians since the beginning of Confederation. This paradigm can best be described as internal colonialism, whereby the greater part of Canada's Indians have been given separate legal status by virtue of an Indian Act, have been subject to special legislative programs, and have been settled on specific land areas known

> as reserves. In part, this policy fulfilled a perceived need to protect Indians and Indian lands from exploitation by non-Indians. But more important, the long-range goal of internal colonialism has been assimilation. This policy has been based on the belief that social and economic advancement towards equality with non-Indians, a necessary requisite for successful assimilation, could best be achieved in insulated environments, under the tutelage of the federal government.[25]

1966-67: In two volumes, what became known as the "Hawthorn Report" is released. This collection of studies, commissioned by the Department of Indian Affairs, was titled *Survey of the contemporary Indians of Canada — a report on economic, political, educational needs and policies*.[26] It painted what subsequent authors[27] called "a dismal picture of Indian life" in all aspects: health, education attainment, employment levels, housing, and governance. The Hawthorn report called for an increased budget for the department of Indian Affairs and an increased departmental staff, to rectify the massive social and economic problems of First Nations. The federal government chose to respond to the issues raised in the report with the 1969 White Paper, and rejected the Hawthorn recommendations for investments in First Nations.

1969: Jean Chrétien, the Minister of Indian Affairs and Northern Development, presents a White Paper on Indian Policy in the House of Commons[28] which proposes to repeal the Indian Act so First Nation people would be "equal" with other Canadians, turn over responsibility for health and social welfare of Indians to provinces so they can be "cared for as other Canadians are" and phase out the operations of the Department of Indian Affairs within five years and take what is left of the department (the 'northern development' parts) and assign those functions to other federal departments. The paper causes an uproar in "Indian country" and was eventually withdrawn by Prime Minister Trudeau in 1971. The policy turmoil and ambivalence around aboriginal issues has been carrying on since the withdrawal, marked by what some authors call periods of intense short term investments with "millions allocated for economic development, job training programs, and make work and community development programs where none had existed before." Such periods are followed by periods of disappointment, review, and a lapsing in the former fallback policy of benign neglect. One thing has remained consistent, however, whatever seems to happen to the level of federal expenditures on aboriginal issues. "Ever since the [1969] White Paper was brought forward, the [federal] government has been much more concerned with implementation than planning."[29]

1975: The James Bay and Northern Quebec Agreement creates the first independent aboriginal health and social service boards in Canada,[30] beginning the trend towards First Nation management of health services. While it is still a matter of debate whether this Agreement provided a model for future First Nation control over health care programs, this Agreement still represents a benchmark that should not be forgotten. According to the Royal Commission on Aboriginal Peoples (RCAP), the principle problem with the James Bay Agreement from the perspective of local First Nations is that the control over local programs they *thought* they had been promised in the Agreement did not actually materialize on the ground. A similar tension exists today between the perception among government officials, who believe that authority over health care delivery has been "transferred" to First Nations, and the First Nations' perception they have only achieved self-administration (taking over administrative responsibility for programs defined by someone else) not self-government.
1978-79: In 1979, the Government of Canada formally adopted the World Health Organization Alma-Alta Declaration of 1978.

> This declaration was signed by 134 countries, under the auspices of the World Health Organization [WHO], and reiterated the definition of health first published in the 1948 [WHO] constitution. This definition states that "health is . . a state of complete physical, mental and social wellbeing, and not merely the absence of disease," a definition which, while broad, is still considered paramount today.[31]

Later, in 1986, the Mulroney government took the lead internationally in organizing a WHO conference in Ottawa on health promotion which took the next step, and issued a declaration supporting the active promotion of health in all aspects:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.[32]

1979: The Indian Hospital in North Battleford is closed by the federal government. In its place, Battlefords Indian Health Centre is established to provide a wide range of health services to the 10 First Nations surrounding the Battlefords. The Battleford Indian Health Centre (BIHC) which grew out of that partnership was the first Indian-controlled health Centre in Canada, governed by an all First Nations board of directors. Funding was through a contribution agreement from the Medical Services Branch (MSB), the forerunner of FNIHB, long before health transfer was introduced. At that time, MSB had a zone office, a district office, a Saskatchewan regional office as well as the national office. In 1993, Battleford Tribal Council Indian Health Services (BTCIHS) entered its first transfer agreement with FNIHB. In 1998, BTCIHS underwent accreditation with the Canadian Council on Health Services Accreditation (CHSA), a national, non-government, non-profit organization which develops health standards. FNIHB accepted that CCHSA report as the five-year program evaluation of the transfer agreement. Another five year health services transfer agreement was signed in 1998. In 2001, BTCIHS pilot tested the First Nations and Inuit Community Health Services standards with CCHSA and subsequently was accredited for another 3 years. Accreditation was again received in 2004, with the next full scale review set for 2007. BTC holds up this process as a role model for simplifying and putting under greater community control the entire review process for renewing transfer agreements.[33]

January 22, 1979: An 11 year old First Nation girl, Renee Smith, dies in hospital in Alert Bay B.C. She had been brought to the hospital four days earlier suffering from acute appendicitis, an ailment that does not necessarily lead to death. There was an inquest and subsequently a public inquiry into the death, headed by Dr. Gary Goldthorpe, a former Zone Director for the Medical Services Branch of Health Canada in the Sioux Lookout Zone in northwestern Ontario. Dr. Goldthorpe released his report in May 1979, citing the local doctor involved for negligence in the girl's death, as well as the deaths of two other local aboriginal people. He chastised the College of Physicians and Surgeons for failing to act on long standing complaints about apparent negligent practice of the doctor involved, including frequent reports that he showed up for work at the hospital highly intoxicated on a regular basis and was abusive to staff who suggested he was impaired. The Nimkish First Nation called for greater control over their own health services in order to permanently rectify the problems such long standing poor treatment had created. "The

National Indian Brotherhood's position [to the inquiry] was that good health and good health care could only be achieved by breaking the bonds of dependency on non-Indians and by placing these matters firmly under the control of Indian people themselves. [In the words of the band council brief] Indian control should not be mistaken for a struggle for exclusivity but for excellence."[34]

September 19, 1979: Federal Indian Health Policy announced, the stated goal of which was "to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves."[35]

> Central to this new policy was the belief that a simple increase in health programs and services would not result in a substantial improvement in health status. What was required was increased input by aboriginal peoples themselves. Furthermore, the policy emphasized that spiritual health was as important as physical health, thus setting the stage for the re-emergence of traditional healing services.[36]

1980: Thomas Berger releases *Report of the Advisory Commission on Indian and Inuit Health Consultation*

> The consultation began after the announcement of the Indian Health Policy in 1979 . . . as a step towards identifying the shape of the new institutions that would be required to implement the health policy. [Some of the report's recommendations were] not implemented, but the subsequent health transfer process appears to have benefited to some extent from Berger's detailing of community participation. Overall, the report seems to have had little impact.[37]

1982: The Queen signs into law the Canadian Constitution and the accompanying Canadian Charter of Rights and Freedoms, which includes an affirmation of aboriginal rights, stated as follows:

> 35. (1) The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed. (2) In this Act, "aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.[38]

1982: The federal government launched the Community Health Demonstration Program (CHDP), which was designed to be a five-year test of how to provide greater control by First Nations over local health programs. The CHDP was criticized by First Nation leaders at the time because they argued they should not have to demonstrate to "the federal government's medical services branch (MSB) or any other authority that they could manage their own affairs."[39]

1983: The House of Commons Special Committee on Indian Self-Government released its final report, usually referred to as the Penner Report, named after the Chair of the Special Committee, Liberal MP Keith Penner. In the words of a later historical analysis of the evolution of governance policy toward First Nations practiced by the federal government, the Penner Report is seen as proposing "an active and protective federal role to recreate the original partnership that Indians have never ceased to call for"[40] A more recent analysis of the history of self-government policy in Canada prepared by the House of Commons research service[41] concluded that the Penner report marked the beginning of a new period in federal policy:

> The current approach of the federal government [includes]... ***incremental steps*** toward self-government through the transfer of authority or development of ***more flexible funding arrangements*** . . . [42]

The Penner Report and the federal government's reply tabled a year later[43] came in the context of a series of four federal-provincial conferences on aboriginal rights issues held because of the adoption of Section 35 of Charter of Rights and Freedoms in 1982. The constitutional conferences were agreed to because it was seen to be necessary to more clearly define the implications of Section 35. A background paper on aboriginal issues posted on the CBC web site sums up the historical situation that took place after the adoption of the Charter this way:

> The four conferences were a series of constitutionally guaranteed meetings between the prime minister, the premiers and the leaders of the Assembly of First Nations, the Métis National Council, Inuit Tapirisat Kanatami, and the Native Council of Canada in order to identify, define and discuss aboriginal and treaty rights. The conferences led to some progress in the relationship between the federal group and native groups — but, in the end, the federal and provincial governments refused to recognize that aboriginal people already had, through their history, **an inherent right to self-government**[44]

Yvonne Boyer from the Native Law Centre at the University of Saskatchewan[45] makes the legal argument on behalf of the aboriginal perspective[46] that this failure by government to accept the inherent right to self-government results from governments failing to actually come to terms with the implications of Section 35. In effect, the argument here is similar to the one made by George Erasmus in 1986 where he described federal actions as making "use our language, but not the concepts they are meant to convey, in program and policy formation."[47] In general, most scholars of aboriginal policy see the government as adopting the words of the Charter, but not their real meaning in practice. Boyer argues this failure has particular relevance for the debate over whether the government has a fiduciary obligation to provide health care. Citing many other legal scholars, Boyer concludes:

> Despite the entrenchment of Aboriginal and treaty rights in Canada's Constitution (through Section 35) the federal government has not acknowledged the impact of such entrenchment on Aboriginal and treaty rights to health. This paper demonstrates that there is a ***treaty right to medical services, a fiduciary duty to provide medicines, a reasonable and legitimate expectation to receive supplemental medicines and health care, and an Aboriginal right to health***.[48]

Similar to the Cree perspective on Treaty Six, Boyer notes that an aboriginal perspective that they have a *right* to health comes from a wholistic understanding of the treaties, including "promises made to the Indian nations during negotiations rather than the written text of the treaties."[49]

January 18, 1988: Five members of the Sandy Lake First Nation in northwestern Ontario — Josias Fiddler, Luke Mamakeesic, Allan Meekis, Peter Fiddler and Peter Goodman — stage a three-day hunger strike in the lounge at the Sioux Lookout Zone Hospital to draw attention to years of frustration with health care services at the hospital, and back in their home community of Sandy Lake. They stopped the fast three days later only after Health Canada agreed to hold a full scale public review of First Nation health services in the Sioux Lookout Zone. It took until March of 1988 for the inquiry panel to get organized. Retired Anglican Archbishop Ted Scott was named as

the neutral Chairman. Wally McKay, a former Grand Chief was appointed by the Nishnawbe-Aski Nation. A retired doctor and former Zone director of the Sioux Lookout Zone Hospital, Dr. Harry Bain, was appointed by the federal government. Formal hearings opened in Sioux Lookout on September 12th, 1988.

Doctors, nurses and administrators told the inquiry the "system" was doing fine, it just needed more native health care workers and better funding. The First Nation communities complained about attitudinal problems bordering on racism that stopped the federal government from staffing and funding the First Nation health care system properly, and which sometimes showed up in actions of individual doctors and nurses. The panel's final report tried to strike a balance between those two views, by calling for both attitudinal changes, and better staffing and funding. But they suggested the system should remain essentially intact, as native leadership gradually took over through a new Aboriginal Health Authority. That compromise was not acceptable to the Nishnawbe-Aski Nation, the umbrella tribal council for the Treaty #9 area of northwestern Ontario. The panel also called for the amalgamation of the two hospitals in Sioux Lookout, to create one modern facility for everyone, native and non-native. The process to begin that amalgamation began with this report, but took several more years to complete. The fasters said the foot-dragging by Ottawa on self-government, combined with slow decision making toward self-government of the amalgamated hospital, meant to them that the pattern of arrogance and neglect that characterized native health care up until their hunger strike would likely continue.[50]

March 16, 1988: The federal cabinet approves the policy framework for transferring resources for First Nation health programs south of the 60th parallel to First Nation control. The process, as described by Health Canada[51] on its web site:

permits health program control to be assumed at a pace determined by the community, i.e., the community can assume control gradually over a number of years through a phased transfer;

t enables communities to design health programs to meet their needs;

e requires that certain mandatory public health and treatment programs be provided;

r strengthens the accountability of Chiefs and Councils to community members;

s gives communities:

- the financial flexibility to allocate funds according to community health priorities and to retain unspent balances;
- the responsibility for eliminating deficits and for annual financial audits and evaluations at specific intervals;

e permits multi-year (three to five year) agreements;

p does not prejudice treaty or Aboriginal rights;

d operates within current legislation;

o is optional and open to all First Nation communities south of the 60th parallel.[52]

First Nation health organization representatives who participated in the Saskatchewan consultation sessions in March 2005 on capacity development commented that the rhetoric of the transfer initiative was "very appealing, but the reality turned out to be much less than we hoped." Participants noted that while the language of the policy suggests "communities can design health programs to meet their needs," the reality is that the design decisions are actually made by FNIHB, leaving only the management of the delivery of those predefined programs under First Nation control.

September 22, 1988: Montreal Lake First Nation signs a transfer agreement with FNIHB, after years of delay caused by uncertainties in FNIHB because the transfer program was not worked out in detail. A study done by independent academics after the transfer was completed[53] found that the health of the community had generally improved since the establishment of a band-controlled health facility, and the introduction of prevention strategies targeted at issues and people identified by the community. While cause and effect relationships are difficult to prove, the study suggests that the focus placed by the community on addictions and substance abuse issues was likely more responsible for the general improvement in the community's health status than the actual transfer initiative. The ***transfer agreement development process*** was beneficial in getting the community mobilized to define and face up to issues, not the actual transfer agreement that resulted.

The study also documents important lessons about the differences between control and direction of community health services. *Control* means that the health service is managed by staff based in the local community. *Directed* means that the priorities of the health service are determined by the needs of the local community, but that the management of the health service may be located in a larger organization outside the community (e.g., a District/Tribal Council, large Band government organization with several communities, Regional Health Board, etc.). In 1990, the Meadow Lake Tribal Council was the first one in Saskatchewan Region to sign an agreement which made it clear which health duties would be carried out at the local (First Nation) level and which duties would be undertaken by the Tribal Council.

This alignment of services among different levels of jurisdiction among First Nation governance entities remains a matter of ongoing discussion among First Nations, who not only have to work out what allocation of services best meets the needs of their communities, but also which aggregation fits best with the funding formulas of FNIHB. The formulas of FNIHB are based on nationally-determined population and remoteness calculations rather than what works best for the First Nations involved. What the First Nations are trying to work out amongst themselves is what researchers have referred to as appropriate "decision spaces" defining what variations of decentralization of health system delivery are most appropriate given the resources available to work best under local conditions.[54]

1989-1994: On June 29, 1989 the Treasury Board approved authorities and resources to support the transfer of Indian health services from Health Canada to First Nations and Inuit wishing to assume responsibility for health services. This approval implemented the 1988 cabinet decision. A critical review of the transfer initiative published in 1989 in the *Native Studies Journal* and a position paper issued by the Assembly of First Nations argued that the transfer initiative "was ultimately designed to assist the government in reducing its spending on Indian health."[55] Dara Culhane Speck, the author of the *Journal* article (and the book about the Alert Bay inquiry noted above), wrote that the "[transfer policy] does not represent a positive departure from the past or a fundamental change in position by the federal government with respect to Indian health care."[56] The view that the transfer initiative was really a "hidden agenda" to reduce federal expenditures on aboriginal health was reinforced by decisions announced in the federal budgets of 1993 and 1994 which created a financial "envelope" system, which capped expenditures on First Nations health. The envelope system effectively made the financial escalator clauses in transfer agreements redundant or inoperative. Suspicion continues to persist among aboriginal leaders that somehow all federal reform initiatives are really disguised efforts to "offload" responsibility for the costs of Indian health.[57]

1994-1999: Wikwemekong First Nation in Northern Ontario signed its first transfer agreement in 1994, followed by a difficult renewal process which was completed in 1999. A case study completed and published by independent academics[58] notes that the lack of certainty that transfer agreements would be renewed (because they are subject to appropriations by Parliament) causes all First Nations a concern and makes it that much more difficult to recruit and retain health professionals. The study also notes that the initial transfer manuals published by Health Canada mentioned self-determination in health as one of the purposes of the initiative, while later versions of the manual did not.

The study reached the following noteworthy conclusions:

- T "We argue that federal policies regarding Aboriginal health have been conflicting, confusing, and arbitrary."[59]
- 5 "… it can be argued that the policy has, in fact, enhanced local capacity in health governance and administration and, in so doing, has assisted in the initial steps toward self-determination in health care. This is particularly true if one has a long-term, incrementalist view of self-government, a position that the federal government assumes. However, as [this study shows] there remains great dissatisfaction with the Health Transfer Policy at the local level, disenchantment at the unwillingness of bureaucrats to recognize the need for traditional approaches to care, and considerable frustration with the federal government's unwillingness to acknowledge the need for enhanced services given the poorer than average health status of Aboriginal communities."[60] Put negatively, First Nations could be seen as being put in charge of administering their own misery, with no hope of success. Put positively, you can see the glass as half full and Transfer as a development step towards self-government capacity, which is itself one step towards self-determination (something that requires legal/constitutional change).
- l "the Wikwemekong experience confirms earlier criticisms of the Health Transfer policy citing continued external control over the decision-making process. While the policy makers purport that the objective of Health Transfer is power sharing, the actual decision-making system is still hierarchical. Communities are responsible for the administration of the programs, yet have little to no say in policy formation and implementation."[61]

Another study of First Nation transfer agreements in Canada compared Health Canada's policies with similar ones in effect governing indigenous health services in New Zealand and Australia.[62] This study concluded that a more accurate characterization of such health services is "**governance by contract**" — where indigenous health organizations are treated the same way as private sector suppliers of goods and services to the federal government. The contract stipulates what services are to be provided, under what conditions, and for what funding levels, with little or no discretion by the indigenous populations.[63] Academic literature about contracts as a mechanism point out there are limitations to such approaches to governance — notably limiting the scope of what can be learned by both sides to whether the contract has been upheld, rather than seeing wider, more important aspects of the relationship.[64]

Provinces, in contrast to First Nations, have become used to receiving block transfers of money for general health purposes, without detailed reporting requirements. Provinces are usually able to plan their annual budgets, secure in the knowledge that funds flowing from the federal government will be there because multi-year agreements have been signed between *governments*, not between contractors and clients, as First Nations sign with the federal government.[65]

September 1996: The Auditor-General reports to Parliament on the relationship between First Nations and the Government of Canada, noting that "As the relationship between the federal government and First Nations evolves, the issue of accountability continues to present difficulties to all parties." The report, based on interviews with key informants in First Nations and one Tribal Council, noted that the informants:

> "felt that it is essential that both First Nations and government have clear and commonly held objectives, that audit meet the needs of their communities as well as of government, and that the focus be on ***results*** as opposed to ***process***. Taken together, these factors fit within most definitions of accountability. In an area as complex and contentious as this, it is encouraging to see that these First Nations hold views that appear, to some degree, to be consistent with such definitions."[66]

November 21, 1996: Final report of the Royal Commission on Aboriginal Peoples (RCAP) released. In the words of Laurel Lemchuk-Favel, the Commission "provided a new paradigm for Aboriginal peoples' health" after "conducting the most extensive and comprehensive consultation in the history of indigenous peoples." This new paradigm, she writes, has four elements:

1. Equity of health and social welfare outcomes
2. Holism in the diagnosis of problems, their treatment and prevention
3. Aboriginal peoples' control over health systems
4. Diversity in the design of systems and services.[67]

The specific recommendations of RCAP relevant to capacity development in First Nation health organizations can be found in Volume 3, *Gathering Strength*. It calls on all levels of government to work in partnership with aboriginal organizations to develop and implement a "comprehensive human resources development strategy" with a specific target to "train 10,000 aboriginal professionals over a ten year period in health and social services, including medicine, nursing, mental health, psychology, social work, dentistry, nutrition, addictions, gerontology, public health, community development, planning, health administration, and other priority areas identified by Aboriginal people." [68]

The RCAP vision for reorganization of aboriginal health care delivery began with a vision of primary care delivery point taking place in local healing centres, supported by specialized services coordinated at the regional level. The healing centres, RCAP argued, could exist in cities as well as on reserves.

October 1997: Auditor General's review of FNIHB concludes that Health Canada "does not monitor contribution agreements effectively" and that even though a "sound framework for the transfer of health programs to community control has been developed and has allowed First Nations to start managing their own health programs . . . this framework has not been fully implemented."[69]

September 28, 1999: Duane Adams[70] from the Saskatchewan Institute of Public Policy releases his report as the facilitator trying to find a way to address problems between the Meadow Lake Tribal Council and Health Canada over the implementation of the MLTC's transfer agreement, signed in 1991. The report concludes that the envelope spending system instituted by the Government of Canada severely crippled the relationship between the two parties and basically

undermined good will which had developed between the parties when the transfer agreement was first signed. In the words of the report:

> f The event which triggered and has sustained the present MLTC/Health Canada conflict is the federal government's policies on cost containment and the approach taken to the policy implementation with First Nation's by Health Canada. The effect of these policies and approaches have given evidence to MLTC of the federal government's lack of recognition of the Transfer Agreement and the invalidation of the binding nature of the Transfer Agreement between Health Canada and MLTC.
>
> t The Transfer Agreement had caused a positive new working relationship to emerge between Health Canada and MLTC, which relationship was also reflected in a national policy statement by the Minister of Indian and Northern Affairs. This relationship was severely undermined by the unilateral and dogmatic approach of Health Canada in imposing its national cost restraint fiscal policies resulting in many consequential misunderstandings and suspicions with MLTC. The result is that MLTC believes that Health Canada is in breach of the Transfer Agreement, and perhaps the MLTC treaty rights. The Facilitator has concluded this is potentially true if it were tested in court.[71]

Adams laid the blame for the failure to resolve the differences between Health Canada and MLTC at the doors of federal officials in Ottawa, noting that there had been a relatively cordial relationship between FNIHB regional officials and MLTC. However, Ottawa-directed policies and administrative procedures had, according to the facilitator, basically failed to adapt to the realities of the transfer agreements, leaving a policy void and the impression by MLTC that Health Canada had essentially "abandoned"[72] the transfer agreements.

In response to the recommendations of this report, FNIHB committed an additional $270,000 to MLTC nursing on an ongoing basis, but took no action to address the facility designation issues that were central to Adams' findings. Other bands and tribal councils with transfer agreements have a similar problem, because capped funding from FNIHB has not allowed the agreement holders to keep pace with inflation or population increases.[73]

October 2000: Auditor General's report reviews Health Canada's performance since 1997 and expresses a concern "that the Department has not yet made sufficient progress to fix many of the problems we identified in 1997."[74] The House of Commons Standing Committee on Public Accounts hearings on the Auditor-General's report prompted a lengthy reply by FNIHB and several initiatives to address accountability issues. In the words of one FNIHB document tabled with the Standing Committee:

> Milestones for [improved management of] CHP [Community Health Programs] in 2001-2002 included the introduction of **new standard agreements** and other types of contribution agreements which clarified roles and responsibilities. An electronic system to manage contracts and contributions was implemented nationally. This single management system for contribution agreements will enhance the ability to report, monitor and audit. In March 2002, an Intervention Policy was introduced to guide FNIHB's actions in communities which have been unable or unwilling to address exceptional or problem situations.[75]

It should also be noted that in the same year this Auditor-General's report was released, there were many questions being raised in the media and in the House of Commons about dubious expenses at the Virginia Fontaine Addictions Centre in Manitoba. One report at the time called the situation an "accountability crisis" in FNIHB.[76] In October 2000 Health Canada ordered a forensic audit of the funding to the Centre, which was being provided under a transfer agreement. A news release on the Health Canada web site dated January 30, 2004, about the release of that forensic audit report and the subsequent RCMP investigation, adds detail about what the department did to deal with the accountability issues being raised:

> Health Canada has made significant efforts to enhance accountability, and to strengthen the management of public funds. Among these, Health Canada has developed and implemented **new standard agreements**, which include a more rigorous approval process that allows for an independent peer review. These controls also include a new audit regime following professional standards, as well as a quality control function to ensure policies and procedures are followed properly. These initiatives ensure that the development, approval and administration of these agreements is appropriate.[77]

Several First Nation health managers (not to mention regional FNIHB employees) have commented that, since this 2000 "tightening up" on agreement management, FNIHB Saskatchewan has not been allowed to practice the local flexibility it used to with agreements, thus undermining the ability of the transfer initiative to be more adaptable to local conditions and circumstances, a key component of developing truly accountable organizations. The message that the Auditor General was trying to deliver on the need to focus on "results as opposed to process" in 1996 appears to have been forgotten, since the national "tightening up" which came after the Virginia Fontaine Addictions Centre situation created standard format funding agreements which focus on process, not the achievement of locally-defined health outcomes.

April 11, 2001: Saskatchewan Royal Commission on Medicare releases its final report. Commissioner Kenneth J. Fyke makes integration of health services and the establishment of regional "primary health care teams" key themes of his recommendations:

> The Commission . . . recommends the integration of many of the existing hospitals and integrated facilities in the province into Primary Health Networks. Specifically, the Commission recommends a network of Primary Health Centres as well as Community Care Centres in 25 - 30 locations . . .[78]

This emphasis on integration and better coordination of health services was picked up nationally by the Romanow Commission (see below) and specifically applied by Romanow to the field of aboriginal health and has continued to this day as a major theme of health care reform in Saskatchewan.[79] Fyke himself did not devote a lot of attention specifically to aboriginal health issues, except for his recommendation for the development of a health strategy for northern Saskatchewan. His emphasis on integration and coordination is also evident in his call for a renewed emphasis on a population health approach, to supplant the traditional emphasis on providing medical care to individuals. On accountability, Fyke recommends "clearly defined and measurable population health goals should be developed and adopted across the province."[80]

March-April 2002: Regional meetings of First Nation Chiefs are held in western Canada concerned with the new standardized agreements being imposed by Health Canada. The agreements were to be signed by the end of March 2002 but many First Nation health

organizations refused to sign because they felt the wording of the new agreement form did not recognize treaty rights to health. The Chiefs accused Health Canada officials of telling different bands different stories about the meaning of the language in the agreement, even though the same agreement template was being rolled out nationally. They also questioned why further accountability requirements are being imposed on First Nations while the federal government refuses to be held accountable for its performance in meeting its treaty obligations.[81] Health Canada eventually adopted slightly different legal wording in the agreements which indicate that nothing in them detract from treaty obligations. First Nations are not happy with this completely, but agreed to sign in order to continue receiving funding for health programs.

November 2002: Roy Romanow's report on the future of health care in Canada released titled *Building on Values: The Future of Health Care in Canada*. The report includes a chapter on aboriginal health which calls on federal, provincial and territorial governments, in partnership with aboriginal organizations, to "establish a framework agreement" on how to "consolidate funds that can be used to improve health and health care for aboriginal peoples" within each province and territory. The report advocates primary health care centres as key to building improved health outcomes in aboriginal communities, both on and off reserve.[82] The Romanow approach to integration of services is similar to the one advocated by Fyke, except Romanow specifies how he believes it can and should be applied to address the jurisdictional quagmire surrounding aboriginal health. The national and federal/provincial/territorial "blueprints" for aboriginal health (which were tabled at the Kelowna First Ministers' meetings with national aboriginal leaders in November 2005) appear to be in line with Romanow's integration recommendations, if not as comprehensively as the Romanow report recommended.

On the transfer initiative of FNIHB, the Romanow report comments on the controversy surrounding the spending envelope system which imposed a cap on funding under the transfer agreements. On capacity development of First Nations the report notes:

a [Even though] funding can be transferred . . . it is difficult to transfer knowledge and experience in addressing a variety of health care issues "on the ground." It will take time for communities to develop experience and networks of contacts to solve specific health problems.

p Health Canada indicated to the Auditor General of Canada [response to the 2000 report noted above] that while the transfer initiative allows First Nations and Inuit to take charge of community-based services, its aim is not to modify the general approach to health problems.[83]

The chapter on aboriginal health concludes by recommending that the "general approach to health problems" has to change, because the status quo has not resulted in substantial improvements in aboriginal health. Instead, Romanow's report calls on all levels of government to use the "integrated" model of funding, coordinating all health funding for aboriginal communities through one central source, which he did not specify. Other studies have suggested that reviews of the health system such as Romanow's generally fail to make an important distinction between investments in population and public health approaches, which can lead to reduced acute care costs in the long run, and the rising costs of acute care.[84] One of the principles of First Nation health at the community and tribal council level is that prevention and community-based, population health programs are primary, leaving the acute care system largely in the hands of provincial health authorities.

November 2002: The Federation of Saskatchewan Indians, the Government of Canada and the Province agree to release a joint discussion paper[85] on the respective parties' understanding of "treaty rights to health" in the modern context and understanding of the treaties. This is only a discussion paper, but its positive tone is an indicator that the Governments of Canada, Saskatchewan and FSIN have worked together in the past to try to revitalize the treaties in a modern context, and this paper is an attempt to put "community conceptions" of health on the table as the way the FSIN and elders conceive of what was agreed to in health when the treaties were signed.

December 2002: Auditor General's report on reporting burdens imposed by the federal government on First Nations finds:

> "overlap and duplication among the required reports. With the exception of some financial reports, limited use is being made of the reports by the federal organizations sampled, and we suggest that fundamental change is required. We found the following:
>
> f reporting requirements are dictated, not based on consultation.
> r the information reported is generally not used to set funding levels.
> t the reports contain information that does not reflect community priorities.
> t we noted that new reports are being introduced with little or no review of the reporting requirements for existing programs, adding to the reporting burden.
> r there is little feedback to the First Nations, except for an analysis of audited financial statements.
>
> 1.3 We are concerned about the burden associated with the federal reporting requirements. Resources used to meet these reporting requirements could be better used to provide direct support to the community. Steps need to be taken to streamline reporting requirements. The current program structure established by the federal organizations is an obstacle to reforming reporting requirements and needs to be reviewed." [86]

FNIHB has established a national task force which has made recommendations to trim the paperwork burden on First Nations, in response to this Auditor-General's report. However, from the perspective of First Nations, these moves are seen as insufficient, leaving them with reporting burdens which are still forcing them to collect (in the words of one participant in the March 2005 capacity development consultations) "useless information for reports that FNIHB files and forgets."

February, 2003: Another cost comparison study is completed, this time focusing on the situation at the Saskatoon Tribal Council.[87] The study concludes that health expenditures per capita by Health Canada for the STC area in 2001-02 was 58.6% of the national average. Specifically, the study concluded (quote):

- s The population estimates used by Health Canada are questionable, both conceptually, and compared to the estimates available from DIAND.
- a A significant underestimate of the population of the Yellow Quill band, of about 300 people in 2001-02, amounting to about 9% of the STC population, has never been corrected by Health Canada

2 There has been minor increases in funding levels per capita for Regular Programs and MCARR in constant dollar terms, between 1995-96 and 2001-02. A significant boost in 1996-97 has eroded gradually since then.

1 Health expenditures per capita by Health Canada for the STC in 2001-02, for regular health services, special health services, home care, and management and administration, was only 58.6% of the national average, and 53.6% after adjusting for the Yellow Quill population count error. This could be as low as 42% of the regional average for regular programs, if the STC was, in fact, receiving regional average per capita funding for special programs. Non-insured health benefits per capita for the STC were also comparatively low, at about 81% of the national average, while Non-insured health benefits in Alberta were about 143% of the national average.

h While these results do not allow an assessment of the adequacy of health funding for the STC or other First Nations, they do indicate strong evidence that the STC is being underfunded compared to other First Nations, based on its relative circumstances. Thus, if funding is adequate for First Nations in general, it is likely highly inadequate for the STC. Conversely, if it is adequate for the STC, then it is likely excessive for some other First Nations.

F The magnitude of some of the differences suggest that Health Canada should be called on to explain and justify them.

The main lesson to draw from this study is not just the funding shortfall experienced by STC, as important as that is. Rather, the study clearly documents our argument in this paper that FNIHB's funding policies have a created a ***Patchwork of Inequity*** — where there is no clear logic to funds for health as they are distributed across the country, despite the imposition of nationally standardized funding agreement contracts. Some regions are greatly restrained in their spending, while others are less so, resulting in the per capita allocation discrepancy quantified by the STC study. Such policies could be forgiven if such gross inconsistencies were based on greater tolerance for differences in local community conditions, but they are not, because all First Nations chafe under the same rigid nationally standardized agreement system. The preferred alternative would be for FNIHB to decide to act in the best interests of how to move forward locally towards achieving self-government in health by empowering First Nations and regional officials to define agreement management systems that work to build accountable First Nation health organizations. Accompanying such empowerment, there needs to be equitable funding formulas adopted which take into account populations actually served, the levels of professional services being delivered by First Nation health organizations, and the levels of integration in the service delivery system between local First Nations, aggregations of First Nations in health boards, and specialized services provided by Tribal Council entities.[88]

February 5, 2003: Federal, provincial and territorial ministers agree on a new health accord[89] which does not completely implement all the recommendations of the Romanow report, but which commits all levels of government to significant new investments in health care reforms, reducing waiting times for medical procedures, and joint strategies for health human resources.

April 19, 2004: The first Canada-Aboriginal Peoples Roundtable is held in Ottawa, involving the Prime Minister, several federal cabinet ministers, and the national leaders of all the aboriginal organizations. The Prime Minister commits the government to renewal of the relationship with aboriginal peoples founded on the principle of working together as partners:

> No longer will we in Ottawa develop policies first and discuss them with you later. This principle of collaboration will be the cornerstone of our new partnership.[90]

September 13, 2004: Meeting of First Ministers and national aboriginal leaders directs Federal/Provincial/Territorial (FPT) Ministers of Health and Aboriginal Affairs to work with aboriginal leaders to develop national, provincial and territorial blueprints to improve the health status of aboriginal peoples in Canada.[91] Discussions were held in Saskatchewan involving FNIHB, FSIN and the Provincial Ministry of Health on the Saskatchewan Blueprint. FSIN received funding from FNIHB to develop the First Nation component of a regional Blueprint, while the Province of Saskatchewan commissioned the Saskatchewan Institute of Public Policy (SIPP) to hold input sessions to hear from Métis and urban aboriginal organizations and then roll up recommendations for the Métis/non-status stream of the regional blueprint. Progress reports on how the blueprints are developing were reviewed by ministerial officials in June 2005, and while some progress was made, final Blueprints could not be agreed to at the First Ministers' meeting with NAOs in November 2005 (see Kelowna agreements, November 2005, below). The national teams working on the Blueprint issued a template of six subject areas they expected the regional blueprints to follow, and Saskatchewan's eventual blueprint did:

1. delivery and access
2. sharing in improvements to Canadian health care
3. promoting health and well-being
4. monitoring progress and learning as we go
5. clarifying roles and responsibilities between governments and organizations
6. developing on-going collaborative working relationships

November 4-5, 2004: The Canada-Aboriginal Peoples Roundtable (CAPR) held a health sector follow-up session in Ottawa involving nearly 100 senior officials from national aboriginal organizations, the federal, provincial and territorial governments. The report from that session concluded that the participants called for, among other things:

c greater collaboration between and amongst governments to break down jurisdiction and control issues for First Nations [health]
c more attention and support is required in building human capacity at the community level
m First Nations control of integration of [what services are] provided by different jurisdictions
j an ongoing process that engages Aboriginal peoples and governments at the national, provincial, territorial, regional and local levels to work out details of integrated health services
s achieve accreditation and training of 10,000 professionals [as originally called for in the 1996 RCAP report][92]

November 23, 2004: Another report is released concerning the financial issues in Meadow Lake Tribal Council.[93] Ever since MLTC assumed responsibility for nursing services under their transfer agreement in 1994, MLTC was complaining about how underfunded their nursing services were. This led to the 1999 Duane Adams report, noted earlier. Since that time, FNIHB provided an ongoing nursing funding increase to MLTC in 2000/01, and one-time funding increases in 1999/00, 2000/01 and 2003/04, as well as nursing sustainability funds in both 2003/04 and 2004/05. However, MLTC continues to experience a deficit which they attribute to nursing costs, and advised Saskatchewan Region FNIHB that without significant ongoing increases, their nursing services are not sustainable. This study was commissioned to attempt to quantify the funding gap and make recommendations for closing it. It compared service levels and staffing costs experienced by MLTC to Health Canada-operated nursing stations in the Sioux Lookout Zone, in northwestern Ontario. The study found that the funding per FTE nurse doing comparable work in

the Sioux Lookout Zone was at least a $20,000 per year higher per FTE (full time equivalent) in MLTC. Despite this, the two nurses who did the study found the level of care and immunization to be high in MLTC. Three options were discussed in the study. If the current funding level is maintained, the nursing service as it stands would not be viable and service would have to be reduced to match the available funding. This includes reducing the 24/7 service in the communities that really should not be operating that level of service, given the funding they receive. This report and the Duane Adams report also noted that part of the funding shortfall (about $1 million annually) was caused by on-reserve clinics providing services to off-reserve Métis populations in adjacent communities, services which are not reimbursed by the provincial government.

It should also be noted that another study which compared the Sioux Lookout Zone's resources to service and funding levels elsewhere in Ontario concluded that the Zone was not receiving *its* fair share of resources, if a population needs approach was taken to allocating health resources.[94] The funding gap being experienced by MLTC may thus be even larger than what was documented in the 2004 study, since Sioux Lookout Zone was used as a benchmark.

January 25-26, 2005: Aboriginal Roundtable follow up session convened in Ottawa to discuss "accountability for results," one of the key themes established in the original roundtable. The report from these sessions, among other things, calls for:

- r creating accountability and reporting frameworks that build in traditional values and approaches from First Nations
- a the system now places much higher value on the accounting for the money and not as high a value on priority outcomes
- a accountability needs to be built from the bottom up
- a First Nations . . must have the control and authority to establish their own relevant frameworks.
- f relevant data and determinants need to be redefined in order to be helpful in building standardized yet relevant approaches
- s an independent monitoring authority should be established at arms length from both the federal government and national aboriginal organizations which would report annually to Parliament and Canadians on progress being made towards achieving the goals established by the roundtable, not unlike the reporting system recommended by RCAP[95]

February 23, 2005: Federal budget repeats commitments made at FPT ministers meetings to establish or augment funding for several aboriginal initiatives. To quote from the Budget:

> While awaiting the completion of the Canada–Aboriginal Peoples Roundtable process, Budget 2005 provides $735 million in new investments aimed at ensuring that the country's prosperity is shared by Canada's Aboriginal people and communities. This is in addition to the $700 million over five years for Aboriginal health programs announced in September 2004. Budget 2005 measures include:
> - h $295 million over five years for housing construction and renovation on reserves.
> - $ $100 million over the next five years to enhance early learning and child care opportunities for First Nations children and families living on reserves.
> - f An additional $120 million over five years for special education for First Nations children living on reserves.

- **3** $125 million over five years to support the work of First Nations child and family service agencies.
- a $40 million so that the Aboriginal Healing Foundation can continue, for another two years, to support community-based healing projects that address the legacy of physical and sexual abuse in the Indian residential school system.[96]

The $700 million over five years originally announced in September 2004 and reconfirmed in the February 2005 budget is described as follows:

- F $200 million for an **Aboriginal Health Transition Fund** to enable federal, provincial and territorial governments, First Nations governments who deliver health care services, and Aboriginal communities to devise new ways to integrate and adapt existing health services to better meet the needs of all Aboriginal people.
- t $100 million for an **Aboriginal Health Human Resources Initiative** to increase the number of Aboriginal people choosing health care professions; adapt current health professional curricula to provide a more culturally sensitive focus; and improve the retention of health workers serving all Aboriginal peoples, including First Nations, Inuit and Métis.
- a $190 million to make permanent and enhance the Aboriginal Diabetes Initiative.
- $ $65 million for an Aboriginal Youth Suicide Prevention Strategy.
- $ $145 million for maternal and child health, including enhancements in early childhood development.[97]

March 2005: Centre for Aboriginal Health Research releases a national evaluation of the FNIHB transfer policy. The report concludes that, on the whole, the transfer initiative "has met its objective of enabling First Nation and Inuit organizations to design health programs, establish services and allocate funds according to community health priorities."[98]

On capacity development, the same study notes:

> A majority of respondents (65.6%) replied that their health organisation had indeed been able to develop administrative, management, service delivery and programming skills. The majority of respondents to the telephone survey (66.9%) indicated that FNIHB was not seen as a source of support for capacity development. Provincial and private resources (consultants) were preferred simply because of the variety of opportunities offered, and the possibility of having adapted training sessions delivered locally.[99]

On accountability and reporting burdens, the study noted that the current reporting regime does not meet FNIHB's need to monitor the performance management of the health care provided to First Nations:

> The current reporting framework is designed to meet FNIHB's chain of accountability and to manage risk. The focus is on risk management for individual agreements, and may satisfy individual program manager's need to document performance. However, it is clear that FNIHB requires a different kind of data to exercise its role of steward over the overall performance of the health care system for First Nations and Inuit, and for monitoring expenditures of public funding. The issue is that there is currently no mechanism to collate the collected data into

> information on which to base decisions. The problem is one of both volume and format. ***The current system can not roll up current information into a format that would provide the Minister of Health with the information required to meet the accountability requirement of Cabinet.***
>
> The cost effectiveness of the current system has also not been considered. FNIHB is currently engaged in the streamlining of reporting requirements, and indicates that it has reduced requirements in 20 per cent of the schedules by simply eliminating duplication. However, ***neither a reduction nor an increase in the number of reports and current indicators will provide FNIHB with the information it needs to oversee the system***.[100]

On accountability, the report found that while the majority (63.6%) of First Nations with transfer agreements were satisfied with the degree of accountability to the community, this

> improved accountability has not necessarily been the result of the accountability framework implemented by FNIHB. Two thirds of organisations surveyed report having been able to develop a useful reporting system to serve their internal needs. However, the development of a Health Information System that would assist First Nation and Inuit organisations in meeting their planning and reporting expectations, has been slow and difficult.[101]

On funding levels, the study found that there was a wide variation across the country in per capita funding levels provided under transfer agreements, and that generally the "current funding formula is ***not sufficient to maintain a sustainable system***."[102] On the system as a whole, the report concludes that because many targeted programs are not transferred, even First Nation health organizations with transfer agreements are still coping with complex administrative and reporting requirements, without the resources required to cope:

> ***The overall picture is that of a patchwork, not a system***. The administrative cost of maintaining this patchwork of agreements, with their periodic amendments, is considerable. At a time when financial sustainability is a concern, cost effectiveness in administration should be pursued.[103]

March 29-30, 2005: Federation of Saskatchewan Indian Nations (FSIN) health summit held in Saskatoon. A draft health strategy for First Nations in Saskatchewan is tabled containing basic principles as well as seven strategic directions for First Nations health care:

1. Strengthen and revitalize First Nations partnerships.
2. Design and implement a First Nations health management framework
3. Strengthening the First Nations health care system
4. Encourage, promote and develop effective and accredited First Nations health education and training
5. Determine priority health areas for Saskatchewan First Nations and initiate action strategies to meet these needs
6. Develop an optimal First Nations health information management system
7. Develop an evaluation framework to assess the impacts of proposed strategies.[104]

At the Saskatoon summit the Assembly of First Nations (AFN) made a presentation[105] of their understanding of the current situation with health care reforms and the Aboriginal Roundtable and Blueprint discussions. Key elements of this presentation were:

- B the AFN said they perceived a "commitment to transformative change" among national and provincial leaders.
- p the AFN understood the first ministers to be willing to move "beyond consultation to joint policy development" with aboriginal leaders on improvements to health care.
- p the AFN supported the approach being taken by FPT ministers generally with health care reform to work "within a population health approach" and to develop a ten year plan that would "focus on quality, accessibility and sustainability."

April 1, 2005: Treasury Board authority for FNIHB to enter into transfer, integrated and contribution agreements with First Nation communities and organizations is renewed. New, "flexible" funding agreements are supposed to be in effect for all types of funding (previously known as transfer, integrated or contribution) for April 1, 2007.

June 24, 2005: FNIHB Saskatchewan receives and approves in principle the recommendations of the Capacity Development Working Group. The report[106] makes several recommendations to guide FNIHB as it examines how best to implement potential new funding for First Nations that might be forthcoming through the $700 million package and/or the FMM blueprints. The report was developed after consultations with health organizations in three regions of the province, and was sent by the Regional Director to all First Nations and Tribal Councils after it was adopted.

November 18, 2005: The Province releases an extensive review of the training system, covering all aspects of post-secondary education and apprenticeship in Saskatchewan except the universities. The report[107] makes 121 recommendations but is strongly opposed by SIAST, because it recommends that SIAST lose its "monopoly" on certification of training courses managed elsewhere such as at the regional or aboriginal colleges. The report also calls for a 30% increase in capacity in the training system to accommodate the needs of a booming economy and the aboriginal populations.

November 24-25, 2005: The leaders of the five national aboriginal organizations and the leaders of all provinces, territories and the federal government meet in Kelowna, British Columbia. Several documents are tabled at this meeting. The ones relevant to aboriginal health in Saskatchewan are two.[108] First, in the words of the Province of Saskatchewan, an "*Aboriginal Blueprint - Saskatchewan Approach* document is built on the priorities that emerged from provincial blueprint engagement sessions and submissions, and identifies actions that will be undertaken by the Province of Saskatchewan and the federal First Nations and Inuit Health Branch (FNIHB) - Saskatchewan Region in collaboration with Aboriginal peoples. This document was developed as a starting point and does not represent a final blueprint plan for the province." Secondly, the national meetings (in the words of the Government of Saskatchewan) "concluded with a commitment to take action to improve the health of Aboriginal peoples. Areas of focus include:

- i mental health, suicide, and addictions
- m nutrition and food security
- n diabetes prevention and treatment
- d public health
- p continuing care

- **3** telehealth
- t maternal, child, and youth health

The national Aboriginal health blueprint was released as a "work in progress" and will lead to the development of plans at the provincial level. Saskatchewan Health will work in collaboration with First Nations and Métis peoples and the federal government to develop plans that address the needs of Aboriginal peoples in our province." (end quote from the Province of Saskatchewan web site)

December 14, 2005: The Province of Saskatchewan releases *Working Together: Saskatchewan's Health Workforce Action Plan.* [109] While not containing any specific employment targets or yearly workplans, the action plan does lay out a broad conceptual framework and goals. The goals could be used to derive specific targets, but none are clearly laid out. Among other things, the Action Plan commits the province to continue developing a more representative health sector workforce, expand training and development opportunities for people of aboriginal ancestry, and to look into establishing an aboriginal health training and workforce development "virtual centre of excellence," likely to be led by one of the health faculties, but virtually linking all "access" type programs in the post-secondary institutions, as well as the representative workforce initiatives being undertaken by SAHO and First Nation health organizations. The planning for this centre of excellence is to be undertaken in partnership with First Nations in Saskatchewan.

May 16, 2006: Auditor-General Sheila Fraser releases a report[110] following up on previous recommendations she made concerning First Nation issues. Chapter 5 of her report analyses 37 recommendations made in previous reports and finds that the federal government has made "unsatisfactory" progress on 15 of the 37, the 15 considered by the Auditor-General to be "generally those most likely to improve the lives of First Nations people."[111] Even on the other 22 recommendations where the Auditor-General gave the government a "satisfactory" mark, the report notes that there were several areas where progress was not made, such as moving towards better reporting systems in First Nation health programs where both the government and First Nations agreed on 'measurable health outcomes."[112]

In her news release on the report, Ms. Fraser comments: "Where our recommendations were implemented successfully, some critical factors appeared to be co-ordination of programs, sustained attention by management, and meaningful consultation with First Nations. These lessons can guide the federal government as it moves forward in fulfilling its responsibilities to First Nations people."[113]

Conclusions

(1) An incremental approach toward achieving self-government

This historical analysis makes it clear that First Nations are left with no constitutional, judicial, or legislative mechanisms, domestic or internationally,[114] through which they might gain leverage with federal officials to improve their health status. With all these other options eliminated, it is therefore not surprising that many First Nations have opted to participate in the transfer initiative, as a pragmatic policy choice of last resort.

Independent studies of the evolution of self-government institutions among First Nations have concluded that this "step by step" approach is a reasonable one. For example, Cassidy and Bish[115] note that the concept of self-government can evolve in two ways: either from the top down by a series of national agreements or constitutional deals, or from the bottom up, "emerging simply from growing acceptance of practical mechanisms and structures for decision-making and service delivery—that is, through practice."[116]

Cassidy and Bish conclude that many definitions of self-government have evolved simply by the federal or provincial governments acquiescing to the assertion of jurisdiction by a First Nation over certain operational aspects of their lives, such as setting up a peacekeepers organization and unofficially recognizing it as a police force, as occurred between the Quebec government and the Mohawks of Kahnawake.[117] Through such assertion, and by practical application of rights to self-government by making agreements between themselves and other levels of government for services and program delivery, First Nations are defining what they believe self-government to mean in practice, rather than in the courts or through constitutional agreement.

> As they create their governments in practice, Indian peoples are demonstrating which public functions they consider important for their jurisdiction in relation to matters such as education, resource management, social services, health, policing, local services, and economic development.[118]

What the authors do is make a pragmatic case for the evolution of such arrangements under the existing Canadian federal system, where different levels of government exercise their own jurisdiction, making citizens accountable to multiple governments.

> The entire logic of a federal system is that individuals can be citizens of different governments for different purposes—and it is possible to accommodate Indian governments as well as national and provincial governments within such a framework.[119]

The health transfer policy of the federal government is therefore an incremental step towards self-government, but not a substantial change from the policies which began with the signing of Treaty Six. First Nations have made a choice to try out transfer, and therefore have a long track record of building, incrementally, on their own successes.

Other academic studies suggest that, when communities are given control over what data is collected about their health status and have control over not only what that data is, but what to do about it, large gains can be made not only in self-government, but also in health status indicators

such as reducing injuries.[120] We support such visions of local control as a means towards achieving improved health status.

(2) What the patchwork of inequity means for AHHRI work plan and capacity development of First Nations in Saskatchewan

As stated in the introduction and in our overview of the five themes, AHHRI is not designed to address the historical inequities documented in this chronology. AHHRI contains no provision to provide funding to First Nation health organizations to bring the salary levels of their health staff up to those paid for similar positions elsewhere. As a result, First Nation health organizations face ongoing recruitment and retention problems, particularly for professions in high demand nationally and internationally such as nurses, environmental health officers, and senior level planning and management staff. The history documented in this report makes it clear that First Nations are more than ready to take the next step towards self-government in health, as long as the federal government comes to the table with the intent of seeing First Nation health organizations as equal partners, not junior contractors. There was some progress made on this issue in health components of the Kelowna Accord, signed by First Ministers and national aboriginal organizations in November 2005. Several million of the over $1 billion dollars that were committed at the Kelowna meetings were going to address this historical inequity issue. Now, the Kelowna agreements in doubt, seen by the government as policy targets rather than funding commitments, achieving an end to inequality remains in doubt.

In this context, AHHRI is going ahead as an initiative intended to assist in addressing the long term issues related to the development of human resource capacity in First Nation health organizations, and towards recruiting and retaining more aboriginal people generally in health professions. This historical review and our previous capacity development consultations lead us to conclude and recommend to FNIHB Saskatchewan the following concerning AHHRI:

(A) Partnerships should create funding leverage

The Province of Saskatchewan, SAHO and the post-secondary institutions already have made considerable progress, and continue to put an emphasis on recruiting and retaining a representative workforce in their part of the health sector. There are therefore considerable opportunities for FNIHB to leverage the small investments that are possible through AHHRI into considerably larger funding pools to assist in these developments. For example, in the one AHHRI project agreed to already by the region to assist with the development of LPN training at Kawacatoose First Nation, AHHRI funding of $100,000 is only 20% of the overall project budget. The funding will meet start up costs for this innovation in accessibility, but is only one time funding. The province, SIAST and the First Nation will have to seek other resources to keep the project going beyond the first group of trainees. This is highly possible, because of the province's interest in investing in more LPN training, and the interest of the First Nation in providing more employment opportunities for local residents. This example should be used as an exemplary practice for other AHHRI projects where there is an active partnership with the provincial government, academic institutions, and other health organizations.

(B) Focus AHHRI dollars on First Nation health organizations

Several First Nation organizations have already come forward with innovative plans to enhance the management capacity of health staff and/or build on their partnerships with the provincial health

sector to assist with the career pathing of individuals already employed by First Nation health organizations. The diversity and strength of these proposals speaks to the long history of innovation that First Nations have demonstrated in Saskatchewan. These proposals should be supported for immediate funding through AHHRI, as long as requirements for full documentation of "lessons learned" is included either in the local work plan of the First Nation project, or by FNIHB itself. We are at an important point in the evolution of First Nation health governance in Saskatchewan region: First Nations history of innovations and slow development can be used as a foundation for the elimination of the historical patchwork of inequity, and replacing it with a strong network of community-driven accountable First Nation health organizations. But important investments need to be made in the development of human resources in those First Nation health organizations to bring this about. To make sure that AHHRI dollars are not just invested in the organizations that are already strong, we strongly recommend to FNIHB that an allocation of funding for human resource planning and learning be made available across the entire region. This can take the form of First Nation-delivered human resource training sessions on HR planning, as well as funds for each First Nation (either alone or through its tribal council) to conduct a human resource inventory, as a step towards building their human resource plans. FNIHB should then have the task of rolling up all these plans in a year or two and revisiting the HR situation across the entire region with senior leaders of the FSIN, the province, and post-secondary institutions.

We have already made a good beginning, but if we made this investment in human resource planning for ALL First Nations, we will insure that the patchwork of inequity does not continue to be reinforced. Some First Nations will want to develop their own plans, while others already have strong and viable relations with their tribal council. Those with cross-band partnerships will likely be able to move more quickly from HR planning to direct investments in training, as is already proposed by the File Hills Qu'Appelle Tribal Council, and by the Career Pathing pilot project of the Northern Inter-Tribal Health Authority (NITHA) with one of the partners of NITHA, the Peter Ballantyne Cree Nation (PBCN). Because such training and development strategies are related to the overall strategic plans of the organizations involved, the AHHRI investments build on those existing strengths and thus can be incremental improvements towards the goal of eventual self-government in health. Similar approaches need to be followed with all First Nations, including the smallest with the least capacity, in order to make sure that the patchwork of inequity is not perpetuated by AHHRI.

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ENDNOTES

[1] Copies of the strategy were distributed to every First Nation and tribal council representative in June 2005, and was the subject of a follow up session with health directors in Saskatoon in June 2005. Copies of the document are available on request from FNIHB Saskatchewan

[2] Federation of Saskatchewan Indian Nations (FSIN), Government of Canada, & Government of Saskatchewan. (2002). *Health in the context of treaty. A context paper prepared for the Minister of Indian Affairs and Northern Development, the Chief of the Federation of Saskatchewan Indian Nations and the Minister of Aboriginal Affairs for Saskatchewan*. Regina, Saskatchewan.

[3] See particularly Jacklin, K. M., & Warry, W. (2004). *The Indian health transfer policy in Canada: toward self-determination or cost containment?* In A. Castro & M. Singer (Eds.), *Unhealthy health policy: a critical anthropological examination* (pp. 215-234). Walnut Creek, California: Altamira Press.

[4] The first signing of Treaty Six took place at Fort Carlton on August 23, 1876. Other First Nations joined through adhesions and later signings which took place at Fort Carlton, Fort Pitt, Bow River, Fort Walsh and in Manitoba over various years until the end of the 19th century. Further adhesions to Treaty Six continued up until 1956.

[5] For a map showing the initial coverage area of Treaty Six, see INAC's web site at: http://www.ainc-inac.gc.ca/pr/trts/hti/mps/eng/hc1876trty_e.pdf

[6] Jackman, Martha. (2000) Constitutional jurisdiction over health in Canada. Health Law Journal Volume 8, pages 95-104. Citation by Jackman is P.A. Barkwell, "The Medicine Chest Clause in Treaty No. 6" (1981) 4 C.N.L.R. 1.

[7] See page 227 Tobias, John L. 1991. *Canada's Subjugation of the Plains Cree 1879-1885*. Originally published in 1983 in *Canadian Historical Review* Volume 64, Number 3. Reprinted in 1991 in *Sweet Promises: a reader on Indian-white relations in Canada* edited by J. R. Miller, University of Toronto Press.

[8] Tobias particularly challenges a classic Canadian history text, *The Birth of Western Canada: a history of the Riel Rebellion*, by G.F.G. Stanley (University of Toronto Press, 1960), as telling history from mostly the colonizer's perspective.

[9] Tobias, John L. 1991. *Canada's Subjugation of the Plains Cree 1879-1885*. page 232

[10] Tobias 1991, page 222, citing correspondence from Dewdney to the Prime Minister, Sir John A. Macdonald.

[11] ibid, page 224.

[12] Waldram, James B. et al, 1995. *Aboriginal Health in Canada: historical, cultural and epidemiological perspectives* University of Toronto Press, Toronto (citing many other sources), page 149.

[13] See particularly Boyer, Yvonne June 2004. First Nations, Métis and Inuit Health Care: the crown's fiduciary obligation. Discussion paper series in aboriginal health: legal issues, paper #2 (of 3): prepared by the Native Law Centre, University of Saskatchewan for the National Aboriginal Health Organization

(NAHO) October 2004 and posted on NAHO's web site, at: http://www.naho.ca/english/pdf/aboriginal_health_paper2.pdf (accessed June 27, 2006). In this paper Boyer analyzes material about aboriginal health policy from the Romanow Commission on medicare, Supreme Court rulings, and Health Canada's own documents to suggest that the crown is basically in a conflict of interest situation because it has a fiduciary obligation to proactively protect aboriginal rights and should not therefore be deciding, on its own, what health services it intends to provide.

[14] Waldram et al 1995, page 149, emphasis added.

[15] This approach is advocated by the Federation of Saskatchewan Indian Nations (FSIN) in research reports (1979 and 1985) on elder's understandings, passed down through the oral tradition, of the meaning of Treaty Six, cited by Taylor (1985) page 39.

[16] Waldram et al 1995, page 147

[17] Tobias 1991, page 225.

[18] Lux, Maureen K. 2001. *Medicine that walks: disease, medicine and Canadian plains native people 1880-1940.* University of Toronto Press

[19] Patrick Macklem, April 1991. *First Nations self-government and borders of the Canadian legal imagination. McGill Law Journal*, Volume 36, April 1991 issue page 455

[20] Jackman 2000, citing 1971 Saskatchewan Court of Appeal decision by Justice Culliton page 759-60 overturning a lower court finding that a status Indian named Swimmer did not have to pay provincial health insurance premiums because the medicine chest clause "entitled [him] to receive all medical services, including medicine, drugs, medical supplies and hospital care free of charge."

[21] *Treaties as a bridge to the future*, Office of Treaty Commissioner, web page on Treaty Six. http://www.otc.ca/treaty6.html

[22] Waldram, James B. et al, 1995 page 163

[23] *Noble, Wretched, and Redeemable: Protestant Missionaries to the Indians in Canada and the United States, 1820–1900*, by C.L. Higham. University of Calgary Press

[24] Rural health has recently complained about having the same policy fate: being ignored, despite recommendations from the Romanow and Kirby commission reports on Medicare. This places many First Nations inside a compounded series of health policy obstacles, being both rural and First Nation. See Nagarajan, Karatholuvu (2004) *Rural and remote community health care in Canada: beyond the Kirby Panel Report, the Romanow Report and the federal budget of 2003. Canadian Journal of Rural Medicine.* Fall 2004, Volume 9 Issue 4, pages 245-251

[25] Leroy Little Bear, Menno Boldt and J. Anthony Long, 1984. *Federal Indian Policy and Indian Self-government in Canada*, page 70. In *Pathways to Self-Determination: Canadian Indians and the Canadian State*. University of Toronto Press, Toronto

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Hawthorn, H. B. and Cairns, H.A.C. (eds.) *A survey of the contemporary Indians of Canada: a report on economic, political and educational needs and policies*, 2 volumes, Ottawa Queen's Printer, 1966-67

[27] Paul Driben and Robert S. Trudeau (1983) *When freedom is lost: the dark side of the relationship between Government and the Fort Hope Band*. University of Toronto Press

[28]

See Statement of the Government of Canada on Indian Policy, (*The White Paper*, 1969)
Presented to the First Session of the Twenty-eighth Parliament by the Honourable Jean Chrétien, Minister of Indian Affairs and Northern Development. Archived on the INAC web site at:
http://www.ainc-inac.gc.ca/pr/lib/phi/histlws/cp1969a_e.html

[29] Driben and Trudeau 1983, *When freedom is lost*, page 106.

[30] Report of the Royal Commission on Aboriginal Peoples Volume 3, *Gathering Strength*, 1996, page 116

[31] Waldram, James B. et al, 1995. *Aboriginal Health in Canada: historical, cultural and epidemiological perspectives* University of Toronto Press, Toronto page 234

[32]

[33] Janice Kennedy, the Executive Director of BTC Indian Health Services, gave a presentation to a distance education forum on aboriginal health human resource issues in Saskatchewan on December 1, 2005. Her Power Point presentation is the source of this material about BTC's history.

[34] Dara Culhane Speck 1987 *An error in judgment: the politics of medical care in an Indian/white community*. Talon Books, Vancouver, 1987, page 254

[35] *Ten Years of Health Transfer First Nation and Inuit Control* on FNIHB web site, at: http://www.hc-sc.gc.ca/fnihb/bpm/hfa/ten_years_health_transfer/

[36] Waldram, James B. et al, 1995. page 234

[37] Waldram, James B. et al, 1995. page 235

[38] *The Constitution Act*, 1982, Part II, *Rights of the Aboriginal Peoples of Canada.* Official text posted on the federal department of Justice web site, at: http://laws.justice.gc.ca/en/const/annex_e.html#II (accessed December 16, 2005)

[39] Report of the Royal Commission on Aboriginal Peoples Volume 3, *Gathering Strength*, 1996, page 116

[40] Indian and Northern Affairs Canada (undated) *Looking Forward, Looking Back, Part 2: False Assumptions and a Failed Relationship; Chapter 9 - The Indian Act.*
Undated web document posted on line at:
http://www.ainc-inac.gc.ca/ch/rcap/sg/sg27_e.html (accessed June 27, 2006)

[41] Wherrett, Jill 1999. *Aboriginal self-government*. Library of Parliament, Parliamentary Information and Research Service, Political and Social Affairs Division, publication 96-2E, updated and revised June 17, 1999. Available online at: http://www.parl.gc.ca/information/library/PRBpubs/962-e.htm (accessed June

27, 2006)

[42] ibid, page 5, emphasis added.

[43] Canada, 1984. *Response of the Government to the Report of the Special Committee on Indian Self-Government,* presented by the Honourable John Munro, Minister of Indian Affairs and Northern Development Ottawa Ontario March 5, 1984

[44] *Indepth: Aboriginal Canadians, Introduction. CBC News Online*. Nov. 25, 2005 http://www.cbc.ca/news/background/aboriginals/ (accessed June 26, 2006. emphasis added). For a scholarly legal opinion which concludes that self-government of First Nations is a Charter right that the courts could recognize if they chose to, see

[45] Boyer, Yvonne June 2003. *Aboriginal health: a constitutional rights analysis*. Discussion paper series in aboriginal health: legal issues, paper #1 (of 3) prepared by the Native Law Centre, University of Saskatchewan for the National Aboriginal Health Organization (NAHO) October 2004 and posted on NAHO's web site, at:
http://www.naho.ca/english/pdf/re_briefs6.pdf (accessed December 12, 2005)

[46] The Boyer papers were actually prepared for the National Aboriginal Health Organization (NAHO), but similar arguments have been made in other contexts by many other aboriginal organizations in Canada. For example, at a national AFN Chiefs meeting held in Regina in early November 2005, the Chiefs representing bands under the "numbered treaties" pressed the leadership of the AFN for a greater emphasis on treaty rights, fearing that the First Ministers' meeting on aboriginal issues about to take place in Kelowna was going to take a "pan aboriginal" approach that would not only dilute treaty rights by including Métis, but also not respect the diversity of local conditions bands face across the country. (see *Regina Leader-Post*, Tuesday November 1, 2005 pages A1 and 2)

[47] Citation of Erasmus can be found on page 224 of Jacklin, Kristen M. and Wayne Warry 2004. *The Indian Health Transfer Policy in Canada: toward self-determination or cost containment?* Chapter 14, pages 215-234 in *Unhealthy Health Policy: a critical anthropological examination*, edited by Arachu Castro and Merrill Singer. Altamira Press, Walnut Creek California. Citation of Erasmus by authors is from *Native Studies Review*, Volume 2, number 2, 1986, in a *Review* editorial titled *Indian Policy in the New Conservative Government, Part III*.

[48] Boyer, Yvonne 2003, *Aboriginal health: a constitutional rights analysis* as cited previously. page 6, emphasis added.

[49] ibid, page 5, emphasis added

[50] Scott, McKay, Bain Health Panel. (1989). *From here to there: Steps along the way - Achieving health for all in the Sioux Lookout Zone.* Material cited here comes from the report and from news coverage of surrounding events.

[51] *Ten Years of Health Transfer First Nation and Inuit Control*, FNIHB web site:
http://www.hc-sc.gc.ca/fnihb/bpm/hfa/ten_years_health_transfer/

[52] ibid, history section: http://www.hc-sc.gc.ca/fnihb/bpm/hfa/ten_years_health_transfer/#History%20of%20Transfer

[53] Bird, Lionel and Meredith Moore, 1991. *The William Charles Health Centre of Montreal Lake Band: a case study of transfer. Arctic Medical Research* Volume 50, Issues 1-4, pages 47-49

[54] see

[55] Waldram, James B. et al, 1995. page 243

[56] Dara Culhane Speck 1989. *The Indian Health Transfer Policy: a step in the right direction, or revenge of the hidden agenda? Native Studies Review*, Volume 5, Issue 1 pages 187-213. as cited by Waldram, James B. et al, 1995. page 243

[57] The concern about off-loading came up again in discussions in 2005 about national and regional blueprints to improve aboriginal health. The "*Working Outline Of The Aboriginal Health Blueprint*" agreed to by First Ministers and aboriginal leaders included several principles that would guide the development of the blueprints, including the following clause:

> [Principle #7] The Blueprint shall address decision-making and reciprocal accountability to support the Vision and new working relationships – and it will not result in "off-loading."

The fear expressed privately by several provincial officials in the wake of the Conservative government's decision to continue to support the goals of the November 2005 Kelowna Accord, while not providing new injections of federal resources to meet those objectives, will result in de facto off-loading to the provinces and territories to meet the Kelowna targets.

[58] Jacklin, K. M., & Warry, W. (2004). *The Indian health transfer policy in Canada: toward self-determination or cost containment?* In A. Castro & M. Singer (Eds.), *Unhealthy health policy: a critical anthropological examination* (pp. 215-234). Walnut Creek, California: Altamira Press.

[59] ibid, page 215

[60] ibid, page 219

[61] ibid, page 223

[62] Lavoie, Josée G. (2004). *Governed by Contracts: The Development of Indigenous Primary Health Services in Canada, Australia and New Zealand. Journal of Aboriginal Health.* Available online at: http://www.naho.ca/english/pdf/journal_p6-25.pdf

[63] The "governed by contracts" conceptualization of First Nation health policy in Canada has also been accepted as a valid characterization of the current policy framework by Greg Marchildon, former Deputy Minister to Roy Romanow both when he was Premier of Saskatchewan and when he was heading up the royal commission on medicare. In 2006 Marchildon refers to the "governed by contracts" conceptualization in his book evaluating the effectiveness of the Canadian health system using statistical and policy standards established by the World Health Organization, titled *Health Systems in Transition: Canada* 2005 (University of Toronto Press).

[64] For a critique of "governance by contract," see For one set of suggestions for an alternative way to manage aboriginal health funding, see

[65] see the quote in the box on page 1 of this report from Michael J. Prince and Frances Abele, November 2002. *Paying for self-determination: aboriginal peoples, self-government, and fiscal relations in Canada*. Paper presented at "Reconfiguring Aboriginal-State Relations, Canada: The State of the Federation, 2003" conference at the Institute of Intergovernmental Relations, School of Policy Studies, Queen's University

[66] September 1996 Report of the Auditor General, Chapter 13, *Study of Accountability Practices from the Perspective of First Nations*, emphasis added. On the Internet at: http://www.oag-bvg.gc.ca/domino/reports.nsf/html/9613me.html

[67] Laurel Lemchuk-Favel February 22, 1999 *Financing a First Nations and Inuit Integrated Health System: a discussion document*. On the Health Canada web site at: http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/aboriginalhealth/reports_summaries/integrated_health_system.pdf

[68] Report of the Royal Commission on Aboriginal Peoples Volume 3, *Gathering Strength*, 1996, page 269

[69] October 1997 Report of the Auditor General Chapter 13 http://www.oag-bvg.gc.ca/domino/reports.nsf/html/ch9713e.html

[70] Duane Adams was a regional director of FNIHB Saskatchewan and a Deputy Minister of Health for the Province of Saskatchewan before moving on to the Saskatchewan Institute of Public Policy.

[71] Adams, Duane 2001. *Report of the facilitator: towards a collaborative resolution of policy differences concerning the progress of the Meadow Lake Tribal Council and Health Canada (Medical Services Branch)* Executive Summary, pages iii-iv. Saskatchewan Institute of Public Policy. Document released September 28, 1999. Copy available on request from FNIHB Saskatchewan.

[72] ibid, page iv.

[73] See Federation of Saskatchewan Indian Nations, Health and Social Development Secretariat, *Health Blueprint for the Development of First Nations Health Services in Saskatchewan*, (tabled at the Kelowna FMM) November 21, 2005, page 7

[74] October 2000 Report of the Auditor General, Chapter 15. *Health Canada: First Nations Health Follow-Up*. http://www.oag-bvg.gc.ca/domino/reports.nsf/html/0015ce.html

[75] *Government Response to the Standing Committee on Public Accounts on the October 2000 Report of the Auditor General of Canada: First Nations Health: Follow-Up*, May 2002. Emphasis added. http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/bpm/public_accts_govt_followup.htm

[76] Centre for Indigenous Sovereignty, March 30, 2001. *Indian and Inuit Health Careers Program: Environmental Scan final report*. page 4

[77] January 20, 2004. *Health Canada statement on the results of the Virginia Fontaine Addictions Foundation audit.* Emphasis added.

http://www.hc-sc.gc.ca/english/media/releases/2004/statement_vfaf.htm

[78] Fyke, Kenneth J. April 2001 *Caring for Medicare: Sustaining a Quality System. Report of Saskatchewan Commission on Medicare* Page 1, Executive Summary http://www.health.gov.sk.ca/mc_dp_commission_on_medicare-bw.pdf

[79] The Province of Saskatchewan released its response to the Fyke recommendations in December 2001. Most of Fyke's recommendations were adopted by the Province, including his recommendation to replace 32 smaller health districts with 12 regional health authorities and to continue supporting the development of the Northern Health Strategy in which NITHA plays a leading role. The major point on which the Province parted company with Fyke was his call to reduce several rural hospitals to health clinics. For more information see: *The Action Plan for Saskatchewan Health Care* http://www.health.gov.sk.ca/hplan_health_care_plan.pdf

[80] Fyke, *Caring for Medicare* 2001, page 41.

[81] See Barnsley, Paul *Treaty chiefs fight for medicine chest protection*. April 2002 *Windspeaker*, Volume: 19, Issue 12, page 10

[82] Romanow, Roy November 2002 *Building on Values: The Future of Health Care in Canada. Final Report of Commission on the Future of Health Care in Canada* pages 225-225 http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf

[83] Romanow, Roy 2002. *Building on Values*. page 214.

[84] There seems to be an international consensus which has emerged in the last five years, which the Romanow report may have missed, that there is "false dichotomy" (page 342 in article cited below) between public health specialists with a population health approach and health services management with its continuing emphasis on cost containment. Investments in population health lead to lower acute care costs, and governments are starting to recognize that with the appointment of public health ministers in countries such as the UK and the creation of the Public Health Agency of Canada (PHAC). See

[85] Federation of Saskatchewan Indian Nations (FSIN), Government of Canada, & Government of Saskatchewan. (2002). *Health in the context of treaty. A context paper prepared for the Minister of Indian Affairs and Northern Development, the Chief of the Federation of Saskatchewan Indian Nations and the Minister of Aboriginal Affairs for Saskatchewan*. Regina, Saskatchewan.

[86] December 2002 Report of the Auditor General Chapter 1: *Streamlining First Nations Reporting to Federal Organizations*.
http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20021201ce.html

[87] Richard C. Zuker (2003). *A comparative analysis of resourcing levels between government self-allocations and health transfer policy funding: the Saskatoon Tribal Council reality* Zuker & Associates Inc.

[88] For an example of how another country with a large aboriginal population — Australia — is also struggling with how to allocate sufficient resources to meet the needs of a population spread out over a large geographic area while still allowing for local and regional control, see

[89] For more information, see the *2003 First Ministers' Accord on Health Care Renewal* February 5, 2003. http://www.hc-sc.gc.ca/english/hhr/accord.html

[90] Prime Minister Paul Martin speech to Canada-Aboriginal Peoples Roundtable, Ottawa April 19, 2004. Full text of all speeches is in the report from the round table titled *Strengthening the Relationship*. Quote can be found on page 33 of that report.
http://www.aboriginalroundtable.ca/rtbl/strenght_rpt_e.pdf

[91] Various literature reviews of community health have concluded time and time again that individuals' health status is clearly linked to socio-economic conditions. For one such example of a literature review, see

[92] Health Sectoral Follow-up Session, November 2004. *Canada—Aboriginal Peoples Roundtable*. Available for download as a PDF from table of contents at:
http://www.aboriginalroundtable.ca/sect/hlth/index_e.html

[93] Skelton-Green, J., & Scott, J. (2004). *Meadow Lake Tribal Council: review of nurse staffing costs in four communities, final report.* (Power Point version on file with FNIHB quoted here)

[94] Eyles, J., Birch, S., & Chambers, S. (1994). Fair shares for the Zone: allocation health-care resources for the native populations of the Sioux Lookout Zone, Northern Ontario. *Canadian Geographer,* 38(2), 134-150. For further clarity on what is meant by a "population based" approach to allocation of health care resources, see: Birch, S., Eyles, J., Hurley, J., Hutchison, B., & Chambers, S. (1993). A needs-based approach to resource allocation in health care. *Canadian Public Policy*, 19(1), 68-85.

[95] January 25-26 *Accountability for Results* Aboriginal Roundtable Sectoral Follow-up Session: Facilitators' Report. http://www.aboriginalroundtable.ca/sect/acnt/rprt/index_e.html

[96] http://www.fin.gc.ca/budget05/pamph/pasoce.htm

[97] http://www.fin.gc.ca/budget05/bp/bpc3e.htm#abhealth.

[98] Lavoie, Josée G. et al, Centre for Aboriginal Health Research, March 2005. *Evaluation of the First Nations and Inuit Health Transfer Policy*. Volume 1, Executive Summary, page 6

[99] ibid, page 6

[100] ibid, pages 8-9 emphasis added

[101] ibid, page 11

[102] ibid, page 19. Emphasis added.

[103] ibid, page 24. Emphasis added.

[104] page 7 Federation of Saskatchewan Indian Nations, *Strategic Health Plan 2005-2010 for the coordination and development of First Nations Health Services in Saskatchewan*, 3rd draft, tabled at Health Summit in Saskatoon March 29, 2005. The draft plan expands on each of the seven strategic directions.

[105] Power Point presentation by Assembly of First Nations Health and Social Development Commission to FSIN Health Summit, March 30, 2005, Saskatoon, titled *Follow up to FMM*

[106] *Building on Strength: a proposed regional capacity development strategy 2005-2015*. Capacity Development Working Group, Recommendations to Regional Director FNIHB Saskatchewan, June 24, 2005

[107] *A new training model for Saskatchewan: final report of the 2005 Training System Review Panel*, November 2005. The full text no longer seems to be available on the province's web site, but a news release and summary are posted on line at:
http://www.gov.sk.ca/newsrel/releases/2005/11/18-1052.html

[108] Saskatchewan Health has an archive of documents related to health aspects of the Kelowna meetings at: http://www.health.gov.sk.ca/ps_aboriginal_health.htm

[109] A news release and summary of the plan is on the provincial government web site at: http://www.gov.sk.ca/newsrel/releases/2005/12/14-1138.html. The full text of the plan is online at: http://www.health.gov.sk.ca/hplan_health_workforce_action_plan.pdf

[110] May 16, 2006. *Management of Programs for First Nations.* Chapter 5, May 2006 Report of the Auditor General. PDF version available on the Auditor-General's web site at:
http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20060505ce.html/$file/20060505ce.pdf

[111] ibid, page 150

[112] ibid, page 151

[113] News release, May 16, 2006. *Management of Programs for First Nations. Unsatisfactory progress on First Nations issues raised previously*. Chapter 5, May 2006 Report of the Auditor General.
http://www.oag-bvg.gc.ca/domino/media.nsf/html/20060505pr_e.html
(accessed June 21, 2006)

[114] A Senate Committee completed a scathing review of Canada's track record of not living up to its obligations under international treaties which it has been a signatory. The Senate Committee concluded that Canada's practice of signing international agreements but then not living up to them domestically is long-standing:

> Although legislative incorporation is necessary to fully implement treaty rights and obligations, ***the vast majority of Canada's international human rights treaty obligations have not been the subject of implementing legislation***. This means that Canadians cannot, through their courts, compel government respect for their international human rights as such. This appears to be contrary to the spirit if not the actual terms of the international human rights instruments themselves.
> — Canada, Parliament 2001. *Promises To Keep: Implementing Canada's Human Rights Obligations: report of the Standing Senate Committee on Human Rights*. December 2001. Emphasis added. Available on line at:
> http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/huma-e/rep-e/rep02dec01-e.htm

Accessed June 26, 2006. Citation noted is from pages 13-14 of HTML print out.

[115] Cassidy, Frank and Robert L. Bish 1989. *Indian government: its meaning in practice*. Co-published by Oolichan Books and the Institute for Research on Public Policy, Montreal

[116] ibid, from the foreword to the book by the then President of IRPP, Ron Dobell, page v.

[117] ibid, page 158

[118] ibid, page 165

[119] ibid, page 166.

[120] see