BARRIERS TO CHANGE: RCAP AND ABORIGINAL HEALTHCARE IN MANITOBA

THE PERCEIVED IMPACT OF THE ROYAL COMMISSION ON ABORIGINAL PEOPLES ON ABORIGINAL HEALTH, HEALTH SERVICES AND HEALTH POLICY IN MANITOBA

BY

FREYJA ARNASON

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

OF THE UNIVERSITY OF MANITOBA

IN PARTIAL FULFILLMENT OF THE REQUIREMENT OF THE DEGREE OF

MASTERS IN ARTS

DEPARTMENT OF POLITICAL STUDIES

THESIS DEFENDED ON SEPTEMBER 12, 2008

Barriers to Change: RCAP and Aboriginal Healthcare in Manitoba

The Perceived Impact of the Royal Commission on Aboriginal Peoples on Aboriginal Health, Health Services and Health Policy in Manitoba

BY

Freyja Arnason

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

Of

Master of Arts

Abstract

This thesis provides a portrait of the perceived impact of the Royal Commission on Aboriginal People (RCAP) on health policy and systems in Manitoba, through qualitative research and a series of interviews with experienced people in the field of Aboriginal health in Manitoba. The integrating argument for the thesis is that numerous factors can potentially affect the fate of royal commission reports and in the case of RCAP's recommendations on health care for Aboriginal people there were many obstacles to adoption. The thesis identifies constraints within the field of public policy, health policy and Aboriginal policy/politics. The interviews confirm the existence of these multiple constraints. Throughout the thesis, four key cross-cutting issues are also examined: sovereignty, resources, structure and culture. The research reveals that most of the barriers to change in the field of Aboriginal health lie within the realm of public policy and that the federal government must drastically change its approach to dealing with Aboriginal people and issues in order for significant positive change to occur.

Dedication

This thesis is dedicated to my father, Dr. Bruce Arnason. Thank you for your razor sharp insight, your constant support and your passionate belief in the need to meaningfully address the inequities faced by Canada's Aboriginal peoples. I could not have completed this work without your guidance and inspiration.

Special thanks also to my mother, Olivia Arnason, for your endless encouragement and support.

And finally, thanks to my husband, John Thompson, for loving me through it all and for making me laugh.

Table of Contents

Chapter One: Introduction

The health of Aboriginal peoples in Canada is far below the national average. Aboriginal peoples are plagued with elevated rates of illness and disease and a lower life expectancy. The poor health of Aboriginal peoples is tied closely to socio-economic, cultural, historical and political factors that stem from a turbulent past, characterized by racist and oppressive treatment from the governments in Canada and other institutions and individuals within Canadian society[1].

In 1996, the Royal Commission on Aboriginal People called for a new approach to Aboriginal health and healthcare based on: equitable access to services, Aboriginal control of services, and diversity of approaches that respond to cultural priorities and community needs[2]. It has been over ten years since the report was released, and although the health of Aboriginal peoples in Canada has improved slightly, the wide disparity between Aboriginal and non-Aboriginal health persists[3]. There has been a continual struggle between Aboriginal groups and governments in deciding the most effective way to close this gap. Recommendations made by government commissions such as the RCAP are not always supported by all the groups directly affected, or by society at large. This, along with other factors, can result in the outright rejection, delay of major changes in policy and services, or simple inaction. As time passes and other changes in society and policy occur, it becomes increasingly difficult to gauge the exact outcomes of the RCAP.

---

[1] David Alan Long and Terry Fox, " Circles of Healing: Illness, Healing, and Health among Aboriginal People in Canada," in *Visions of the Heart: Canadian Aboriginal Issues*, ed. David Alan Long and Olive Patricia Dickason (Toronto: Harcourt Brace & Company Canada Ltd., 1996), 243.

[2] Canada. *Royal Commission on Aboriginal Peoples.* Report. 5 vols. (Ottawa: Minister of Supply and Services Canada), 1996. vol. 3, ch.3.

[3] Canada. *Building on Values: The Future of Healthcare in Canada – Final Report.* Roy Romanow. (Romanow Report), (Ottawa: Minister of Supply and Services Canada), 2004.

Ideally, social scientists would be able to assess and measure the direct impact of royal commissions on policy and programs, but the reality of changing governments, new agreements, and evolving policy, makes it nearly impossible to directly correlate policy and program changes with the recommendations of royal commissions. Such a task is certainly beyond the scope of this work. It is possible, however, through an analysis of the relevant documents, informed commentaries about activities involved with commission reports and a series of interviews with key people in the field, to study the *perceived* impacts of the Royal Commission on Aboriginal Peoples and the *perceived* barriers, if any, to improving Aboriginal health policy and services. This approach is used as a major part of this work.

Background

In order to fully understand the current state of Aboriginal health in Canada and the role of the RCAP, it is necessary to consider the general situation of Aboriginal[4] people in Canada. The term "Aboriginal" will be used in this work to refer to all Canadians of Native heritage. Census Canada indicates that in 2006 there were 1,172,790 individuals reporting Aboriginal identity in all of Canada's provinces and territories, accounting for 3.8% of the total population of Canada. Of that number 698,025 reported being of First Nations ancestry; 389,785 Métis; and 50,485 Inuit[5].

---

[4] There is no single or "correct" way of defining the Aboriginal population in Canada. It is essential to emphasize that the Aboriginal population is diverse. Section 35(2) of the Constitution Act, 1982, defines the term "Aboriginal" to include "the Indian, Inuit, and Metis peoples of Canada." For the purposes of this dissertation, all people who trace to time immemorial their ancestry in Canada are included under the term "Aboriginal peoples".

[5] Canada. Statistics Canada, *Census 2006 Aboriginal Peoples Highlights.* http://www.statcan.ca/Daily/English/080115/d080115a.htm (accessed 2 April 2008).

These populations are widely dispersed across Canada and found in northern, rural remote areas as well as major cities. Over 175,395 Aboriginal peoples live in Manitoba. Of that number 100,640 are First Nations and 71,805 are Metis and 565 are Inuit[6]. It is estimated that sixty percent of all First Nations people (not including Metis and Inuit) now live off reserve. About three-quarters (76%) of the off-reserve First Nations population live in urban areas. The other forty percent of First Nations people live in over six hundred communities across Canada, the vast majority of which are located in remote or isolated areas. There are two key reasons for this isolation; Aboriginal people historically wished to be close to bountiful hunting and fishing areas; and European settlers were determined to acquire the best agricultural lands for their own use[7]. At times, in recent statistical studies, there is a distinction drawn between on-reserve and off-reserve Aboriginal peoples. However, for the purposes of this thesis, the term "Aboriginal" encompasses both groups. This thesis focuses primarily on the health situation of status and non-status Indians. Although this thesis does not specifically examine the health situation of the Inuit, the term "Aboriginal" does not exclude Inuit populations. Indian, Metis, Mixed-blood and Inuit peoples may be referred to as a group that experienced and continue to experience comparable inferior treatment when contrasted with other groups in Canada.

Since the arrival of European settlers in Canada in the sixteenth century, Canadian Aboriginals and white society have had a colonial relationship[8]. Initially, Aboriginal peoples were valued by European explorers for their ability to guide Europeans and aid

---

[6] Statistics Canada, *Census 2006 Aboriginal Peoples Highlights.*

[7] Bruce Arnason, "Project Management in the Canadian Aboriginal Sector" (Ph.D. diss., University of Bradford, 2001), 15.

[8] Arnason, 16.

them in survival. Aboriginal peoples were also very useful allies in the trade wars between the French and the English. However, as time progressed and the lands were settled, Aboriginal peoples were increasingly viewed as a problem. In the 1870's the Canadian government began to negotiate treaties to obtain valuable agricultural land from Aboriginal groups in exchange for small payments, certain educational and health benefits and exemptions from taxation. Most communities were required to relocate to isolated 'reserve lands'[9]. This reserve system of land allocation and the "Indian Act of 1876" that accompanied it, represented the beginning of an era of legislated inequality, neglect, oppression and discrimination which has not yet ended for Canadian Aboriginal People.

For the first half of the twentieth century, most Aboriginal people resided on their isolated reservations and experienced minimal interaction with mainstream Canadian society. Allan McMillan describes this era:

> For decades Indians could not even leave their reserves without a pass from the agent. Amendments to the Act banned the Potlach on the North-west Coast and the Sun Dance of the Plains, striking at the heart of Native cultures to promote assimilation. A 1927 amendment even prohibited the raising of money to pursue land claims. The Indian Act served to suppress Indian cultures and keep Indians locked in a state of dependency, with little control over their own affairs. [10]

During this time, the Canadian government left the education of Aboriginal peoples to the churches, establishing a system of residential schools. The federal policy of the late nineteenth century focused on assimilating Aboriginal peoples into mainstream society. Residential schools were designed with the goal to "civilize" Aboriginal children into

---

[9] Olive Patricia Dickason, *Canada's First Nations: A History of Founding Peoples from Earliest Times* (Toronto: McClelland and Stewart Inc., 1992), 324-325.

[10] Alan D. McMillan, *Native Peoples and Cultures of Canada* (Toronto: Douglas and McIntyre, 1988), 291.

European ways, which would solve the "Indian Problem"[11]. The residential school system, discussed in further detail in Chapter Two, ultimately initiated a cycle of abuse and a destruction of culture that has had far reaching social effects, resulting in problems such as substance abuse and social and family dysfunction.

Aboriginal people received the right to vote in Canadian federal elections in 1960. Around this time, many Aboriginals began to migrate to the cities in search of a better life. These migrants increased the visibility of Aboriginals to the rest of Canadian Society. They faced an extremely discriminatory world and rarely met with success in the urban centres[12]. As a result, many social problems such as poverty and substance abuse were transferred from reserves into the cities[13]. At the centennial of Canada's confederation in 1967, at Expo in Montreal, Aboriginals organized their own pavilion, where they publicly expressed extreme dissatisfaction with their situation[14]. With the increased attention toward Aboriginal issues in the 1960's, the Government of Canada began to try to improve the situations of Canadian Aboriginal communities. However, the attitude remained rooted in paternalism. The federal government approach was culturally insensitive, and progress was hindered by inadequate funding and assimilationist

---

[11] Jean Barman, "The Legacy of Residential Schools and the Way Ahead," in Visions of the Heart: Canadian Aboriginal Issues, ed. David Alan Long and Olive Patricia Dickason (Toronto: Harcourt Brace & Company Canada Ltd., 1996), 273.

[12] Patricia A. Monture-Angus, "Lessons in Decolonization: Aboriginal Overrepresentation in Canadian Criminal Justice," in Visions of the Heart: Canadian Aboriginal Issues, ed. David Alan Long and Olive Patricia Dickason (Toronto: Harcourt Brace & Company Canada Ltd., 1996), 348.

[13] It is important to note that despite the obstacles Aboriginal people face in Canadian society, many Aboriginals have been very successful. Alan Cairns, an academic in the field of Aboriginal politics stresses that recently there has been an emergence of a significant Aboriginal urban middle class, which is often completely ignored in the discussion of Aboriginal issues and politics in Canada .

[14] Dickason, 383.

policies[15] such as the White Paper, which was issued by the Liberal government of Prime Minister Pierre Elliott Trudeau in 1969.

The White Paper was designed to abolish the existing policy and administration for Aboriginal matters by repealing the Indian Act, phasing out the department of Indian Affairs, terminating the treaties and essentially eliminating the "special status" of Indians. The federal government claimed that the White Paper was a step towards Aboriginal legal, social and economic equality with other Canadians[16]. In the year leading up to the White Paper, the bureaucrats from the Department of Indian Affairs and Northern Development (DIAND) traveled across the country to many reserves to engage Aboriginals in a discussion about their policy and their future. However, when the White Paper was released it became clear that the process of consultation was a sham[17]. As a result, when it was announced it was met with fierce opposition from Aboriginal groups who saw the policy as an attempt to revoke their lands and rights, and to complete the cultural genocide that began hundreds of years before. Aboriginals across Canada joined together to protest the White Paper.

In fact, the White Paper resulted in an enormous increase in research and interest in Indian affairs by Aboriginals, academics and government officials alike[18]. Menno Boldt, a leading author on Aboriginal issues, points out that the consultation process raised the expectations of the Aboriginals and gave them a sense of empowerment which was translated into fierce political protest when they realized that none of their interests,

---

[15] Arnason, 25.
[16] Dickason, 385.
[17] Menno Boldt, *Surviving As Indians: The Challenge of Self-Government* (Toronto: University of Toronto Press Inc., 1993), 66.
[18] Dickason, 387.

rights, needs and aspirations had been heeded[19]. The resistance was so strong that the government finally retracted the White Paper in 1971. The 1969 White Paper was a critical event in Aboriginal politics and policy because it acted as a catalyst to the emergence of Aboriginal nationalism and the development of Aboriginal political organizations. Financial support from the Government of Canada for Aboriginal political organizations also began at his time. The amounts were not large compared to the challenges of organizing a dispersed, varied Aboriginal population whose individual communities were at varying stages of social, economic and political development. For the first time, however, Aboriginal people were encouraged and supported financially to take their case to governments in Canada. Probably the Government of Canada did not realize the extent to which it was launching groups who would become its harshest critics and publicize for the wider society the deplorable conditions which exist in Aboriginal communities and among urban Aboriginals. These issues struck a responsive chord with many Canadians in the late 1960s and early 1970s when there was much talk about the "Just Society" and participatory democracy by Pierre Trudeau.

Awareness of the poor living conditions and the mistreatment of Aboriginal peoples increased throughout the 1970's and 1980's. The government attempted to improve conditions on reserves by funding economic development initiatives in Aboriginal communities. However, despite numerous programs over the period, very little change in economic status of Aboriginal people was achieved[20]. Increasingly, the situation of Aboriginal peoples in Canada became a matter of international embarrassment, and the federal government felt pressure to change the state of affairs.

---

[19] Boldt, 66.
[20] Arnason, 19.

The federal government began to relinquish small amounts of administrative control back into the hands of Aboriginals. However, the government maintained control over policy and decision-making[21]. In the 1990's the federal government of Canada established a royal commission to identify the factors that caused such poor conditions for Aboriginal peoples and to make recommendations for improving the lot of Canadian Aboriginals. One of the key areas examined by the commission was health.

Colonialism, cultural genocide issues, economic disparities, and a quasi-apartheid living situation (the reserve system), have impacted every aspect of Aboriginal lives, including health. The Indian Act and the Treaties resulted in Aboriginal peoples having a unique relationship with governments compared to other Canadians. Along with the legislated inequality and discrimination within these documents, came statutory obligations of the federal government towards Aboriginal peoples. While the federal government is ultimately responsible for policies and issues regarding Aboriginal peoples, health policy is primarily a provincial government responsibility. The provinces therefore have an incentive to disclaim responsibility for Aboriginal populations, creating jurisdictional disputes and delaying important policy and programming decisions. The remoteness of reserves creates logistical problems in terms of the delivery of health services, and there are still some fundamental cultural differences in the approach to health and healthcare. The Canadian history of near cultural genocide has resulted in a host of social and economic issues for Aboriginal people that can be associated with poor health. These are just some of the issues explored in greater depth in the literature review in Chapter Two.

---

[21] Long and Fox, 264.

Statement of the Problem:

There is no clear agreement on what has changed or will change the health status of Aboriginals in Canada. Additionally, there is no consensus on the various dimensions and relative importance of the problem set surrounding efforts to close the health gap between Aboriginals and other Canadians. To some extent, the Royal Commission on Aboriginal Peoples addressed this by identifying some problem areas in its 1996 report, making many recommendations. However, the health gap remains and there is no simple method of measuring the success or influence of the RCAP report and its recommendations.

The purpose of this thesis is to shed light on the apparent influence of the Royal Commission on Aboriginal Peoples on health policy and programming for Aboriginals in Manitoba and to identify perceived problem areas related to closing the health status gap. This will be accomplished by assessing the current state of Aboriginal health policy and programming in Manitoba, examining the recommendations of the Royal Commission on Aboriginal Peoples in relation to Aboriginal health, and obtaining information and opinion from participants in the Aboriginal health care sector through a series of interviews. The respondents will include policy-makers, administrators and Aboriginal leaders in the field of Aboriginal health in Manitoba. Special attention will be given to the interviewees' perceptions of the existing impediments to improving Aboriginal health policy and services and to their perceptions regarding the relative importance of various aspects of the overall problem set.

Analyzing the perceptions of the interviewees will represent a kind of "proxy measure" of the impacts of the RCAP report on policy and programs for Aboriginal

health in Manitoba. Identifying and gauging the full impact of the report is impossible given the multitude of factors potentially involved. However, by capturing perceptions of impacts by informed elites in the policy system, the study can contribute original and valuable insight to how royal commissions have influence. By identifying commonly perceived obstacles to improving Aboriginal health policy and services, this work will highlight important areas for cooperative action in the ultimate pursuit of better health policy and health care for all Aboriginal people. Examining where perceptions differ regarding problem areas, will point to directions for future research to establish the roots of the differing perceptions and to identify potential approaches to increasing mutual understanding with regard to these contentious problem areas.

Thesis Statement

Through a literature review, document analysis and a series of interviews with experienced people in the field of Aboriginal health in Manitoba, this thesis will provide a portrait of the perceived impact of the Royal Commission on Aboriginal People on health policy and systems in Manitoba. The following questions will be addressed in the course of this research:

1. What is the current state of Aboriginal health in Canada?
2. What were the key recommendations made by the RCAP report?
3. What are the perceived impacts of the RCAP on health care and policy in Manitoba?
4. What are the perceived barriers to the improvement of health policy and healthcare as they pertain to Aboriginal people in Manitoba?

In answering these questions, this thesis will contribute to our understanding in

two policy areas of critical importance in Canadian politics: health care and Aboriginal rights. As well, it will increase our understanding of the use of royal commissions as mechanisms for policy change. The integrating argument for the thesis will be that numerous factors can potentially affect the fate of royal commission reports and in the case of RCAP's recommendations on health care for Aboriginals, there were many obstacles to adoption. It is anticipated that the interviews will confirm the existence of these multiple constraints.

Methodology

The methodology for this thesis consists of an extensive review of the literature, and interviews with experts in the field of Aboriginal health in Manitoba. The literature review focuses on published works, government reports, statistics and academic reports. It will include literature on the history of Aboriginal-government relations, as well as current and historic government policies on Aboriginal issues and on health care. The focus of the literature review will be to provide a background to the topic and to establish the current state of Aboriginal health, health care and policy in Manitoba. It will also explore academic perspectives on these issues.

While it is outside the scope of this work to attempt to measure the direct impacts of the Royal Commission on Aboriginal Peoples on the field of Aboriginal health in Manitoba, the thesis will focus on the perceptions of people involved in the Aboriginal health care sector. Interviews will be used to ascertain the *perceived* impact of the RCAP on Aboriginal health care and policy in Manitoba. These perceived impacts can be critically analyzed to determine if government officials and Aboriginal officials have different perceptions regarding the effects of RCAP and to what extent they share

common perceptions. Also, the interviews seek to identify the *perceived* barriers to significant improvement in the field of Aboriginal health in Manitoba. Analysis of these perceptions will help to delineate the problem set involved when considering policy options for the delivery of Aboriginal health care services.

Contextual Framework

To gain a deeper understanding of the significance of this work, it is important to place this research within the larger context of the study of Canadian politics and public policy. More specifically the study draws upon the theoretical and empirical work from three areas of study: public policy, health policy and Aboriginal politics. Given the complex networks of multiple institutions and actors involved in health policy in Canada, it is not surprising that technical changes are more easily accomplished than sweeping policy changes[22]. This is an even more important factor in the specific case of Aboriginal health policy, which involves another network of multiple, interdependent institutions and actors with interests, priorities or agendas that sometimes conflict with one another and make the development of sound public policy very difficult.

The theoretical areas of public policy, health policy and Aboriginal politics, converge, overlap and interact in a network of governance[23]. Understanding these spheres and the way they interact and overlap is essential to understanding the decisions and changes that occur in the Aboriginal health sector in Canada. The Venn diagram that follows represents the areas of theoretical and contextual importance in this research. At

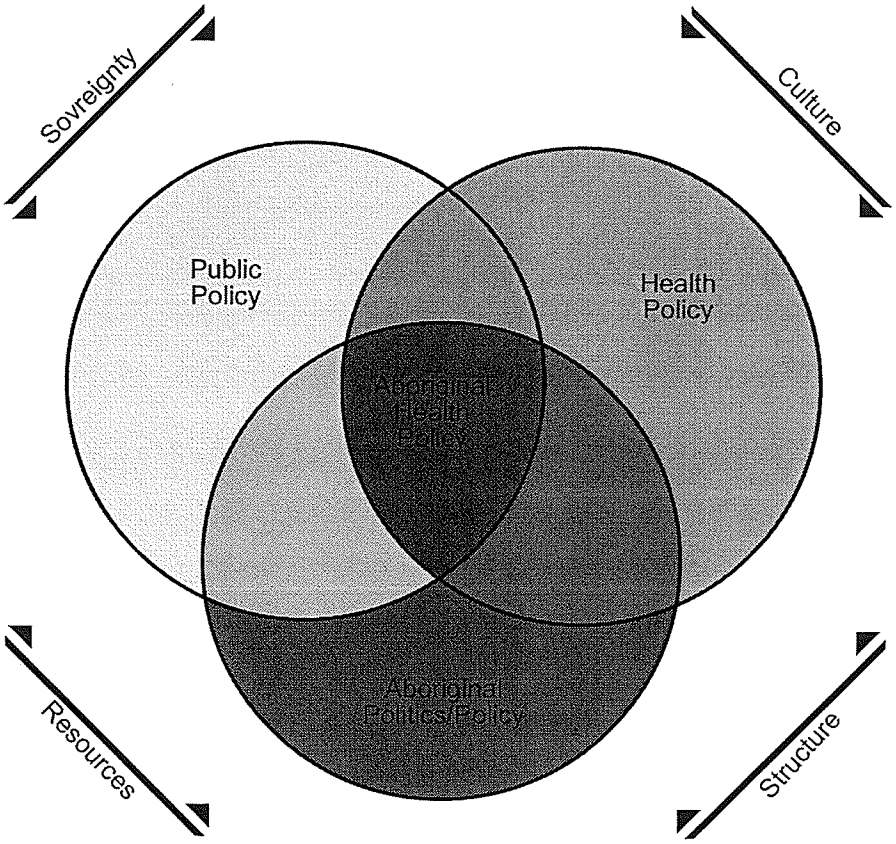
---

[22] Paul Thomas "Challenges of governance, leadership and accountability in the public sector" 128. In Wallace, Michael, Michael Fertig and Eugene Schneller(eds.) Change in Public Services. (London , Blackwell, 2007), 128.

[23] According to Paul Thomas in *Challenges of governance, leadership and accountability in the public sector*, "Governance refers to the creation and execution of activities based upon the complex mechanisms, processes and relationships through which citizens , groups and organizations articulate their interests, exercise their rights, meet their obligations and reconcile their differences" (Ibid.)

the centre of these overlapping theories is the domain where public policy, health policy and Aboriginal politics interact. Examining the dynamics of this domain and of the surrounding fields will both enrich our understanding of the impact of the RCAP on Aboriginal health, health policy and healthcare, and place the research in a theoretical and contextual framework within Canadian politics.

CONCEPTUAL FRAMEWORK AND CROSS - CUTTING ISSUES



ABORIGINAL HEALTH POLICY DETERMINATION

Figure 1

Outline

Chapter One provides a general overview of the topic and establishes the focus of the rest of the work. It includes background information about the substandard nature of Aboriginal health and health care in Canada, the need to improve this situation and the role of the Royal Commission on Aboriginal Peoples in regard to health. The specific area of interest is the impact of the RCAP on Aboriginal health and health care and the perceived difficulties of improving health and healthcare of Aboriginal peoples in Manitoba.

Chapter Two provides a review of the prevalent literature in the field of Aboriginal health and health care policy in Canada, with a specific focus on Manitoba. This includes a brief historical description of Aboriginal health in Canada from pre-contact times to present day, and a description of the present health care policy and programming in relation to Aboriginals in Manitoba. Issues addressed in this section include the roles of the federal and provincial governments, Aboriginal organizations, culture, and bureaucracy in health policy and health care. This will be followed by a special focus on recent Aboriginal health statistics, and the investigation of medical and non-medical factors effecting Aboriginal health. The significance of the health gap will be discussed in relation to relevant themes in Canadian politics.

Chapter Three is a continuation of the literature review, which outlines theories on the roles of public policy, health policy and Aboriginal politics in the process of policy change. Through a look at the theories of Neil Bradford, Peter Hall and John Kingdon it becomes easier to identify issues in the public policy framework that may have influenced the impact of the RCAP on the Aboriginal health sector in Manitoba. The

chapter concludes with a section underlining some possible barriers to the improvement of Aboriginal health and health care in Manitoba, drawn from the literature review.

Chapter Four explains the objectives of the RCAP and its significance in relation to Aboriginal health and health care. It addresses the traditional role of royal commissions and explores the reason for the creation of this particular royal commission. It analyzes the recommendations made by RCAP in the context of the political and economic restructuring that may be necessary for the survival and health of Aboriginal communities, peoples and cultures. The chapter also explores reactions to the RCAP from Aboriginal, government and academic perspectives.

Chapter Five outlines the main changes in Aboriginal healthcare policy, delivery and outcomes since the release of the RCAP report. This will include an exploration of announced changes, new and modified initiatives and perceived changes. Federal, provincial and Aboriginal policy and initiatives will be examined.

Chapter Six will report on the findings of the interviews. It will describe the responses of the interviewees regarding the perceived impact of the RCAP and the perceived obstacles to improving Aboriginal health, health policy, and healthcare in Manitoba. It will analyze the perceptions of the interviewees, in light of key points outlined in the qualitative literature review. In addition, it will compare the varied perceptions of the interviewees, based on their specific roles and affiliations within the Aboriginal health sector. This will potentially allow for some general observations regarding the perceived impact of the RCAP on Aboriginal health and healthcare in Manitoba, and the difficulties encountered in the attempt to alter policy and programming in order to improve the current situation.

Based on the analysis and the findings of this research, Chapter Seven will identify possible policy implications and directions for Aboriginal health organizations, provincial and federal health policy, and the public, with respect to Aboriginal health care.

The concluding chapter summarizes the results of the exploratory research arising from analysis of the interviews with key people in the field. The chapter identifies some of the challenges that must be addressed in the pursuit of improved health for Aboriginal peoples in Manitoba and Canada. The conclusion will then examine the implications of the research for future investigation of the fields of Aboriginal health, health policy and health services.

Chapter Two: Aboriginal Health in Manitoba

To fully comprehend the roots and appreciate the depth and extent of the special health situation of Aboriginal peoples in Manitoba, it is important to provide some historical and contemporary contextual information. This chapter briefly touches on the cultural and social history of Aboriginal–government relations, focusing particularly on health and health policy as it relates to Aboriginals in Manitoba from pre-contact to present day. Although presented in very brief wide-ranging terms, the historical context is essential for the analysis and understanding of the health situation of contemporary Aboriginals in Manitoba. The policy and administrative mistakes and gaps of the past have contributed to the deplorable health status of Aboriginal populations today and to long-standing resentment and mistrust by Aboriginal peoples towards the Government of Canada and to a lesser extent other orders of government in this country. The chapter goes on to identify the nature and extent of the health gap through an examination of recent health statistics, specifically highlighting the prevalence of type two diabetes in Canadian Aboriginal populations. This focus affords the opportunity to explore both medical and non-medical determinants of Aboriginal health.

The History of Aboriginal Health in Manitoba

The following brief outline of the history of Aboriginal health in Manitoba examines health, health policy and programming, from pre-contact to present day. Before delving into this condensed historical overview it is important to define health care. For the purposes of this thesis, a health care system is defined as a method of improving and

maintaining the physical welfare of individuals in a community, typified by a certain set of values and practices.

Aside from the Metis, there are five Aboriginal groups in Manitoba: the Cree, the Ojibway, the Dakota, the Dene and the Ojibway-Cree[24]. Three main linguistic groups have individual territories throughout Manitoba: Athapaskan (Dene), Siouan (Dakota) and Algonquian (Cree, Ojibway and Ojibway-Cree). All of these Aboriginal groups had health care systems pre-dating the arrival of Europeans in North America.

Traditional Aboriginal health care systems were based on a holistic attitude toward health that was vastly different from the interventionist, allopathic medicine of Europeans, which ultimately emerged as the philosophy that would characterize the Canadian health care system. Health care usually comprised a range of healers, herbalists and spiritual practices, which were customarily exchanged in return for goods or services, to complete the healing cycle[25]. Most Aboriginal people possessed enough knowledge of herbal medicine and practices to treat common illnesses and injuries, while certain individuals were specialized healers[26]. This health system represents the holistic wellness model of Manitoba's Aboriginal peoples. The holistic approach requires people to strive for harmony with the earth; emotional, spiritual and physical well-being. According to Long and Fox, "For native people, health implies being in harmony with all of

---

[24]Assembly of Manitoba Chiefs, *Manitoba First Nations Facts.* http://www.manitobachiefs.com/amc/public.html#sectfacts (accessed 30 March 2008).

[25] Assembly of First Nations, *Assembly of First Nations Presentation Notes to the Commission on the Future of Healthcare in Canada* (accessed April 4, 2004) http://www.afn.ca/programs/health%20Secreetariat/assembly_of_first_nations_presen.html (accessed April 4, 2004).

[26]Ibid.

creation…In contrast, western Europeans have long understood health in allopathic, interventionist terms."[27]

Aboriginals in Manitoba shared their knowledge of healing herbs with the explorers, traders and settlers, helping them fight the diseases and illnesses for which the Europeans had no cure[28]. For Aboriginals, however, the post-contact health era was beset with chronic parasitical infections and environmental threats[29]. Europeans introduced new infections to the Aboriginals, including acute diseases such as smallpox and influenza that resulted in severe epidemics. As transportation became easier, these new diseases spread quickly among Aboriginal populations, severely depleting their populations. Towards the end of the nineteenth century, available food resources declined and there was a major change in lifestyle for most Aboriginals as they were moved onto reserves. Tuberculosis, malnutrition and respiratory infections became leading causes of death in Aboriginal communities[30].

Following the Second World War infectious diseases declined rapidly as a result of government intervention in the form of vaccinations and new medical advances[31]. Since that time, Aboriginal populations have been plagued by high rates of chronic diseases associated with modern lifestyle, including diabetes, heart disease and cancer[32]. Health is, of course, a matter of individual and community responsibility but it is also dependent on appropriate and adequate government policy and services. To this date the

---

[27] Long and Fox, 241.

[28] Dickason, 44.

[29] Paul Hackett, From Past to Present: Understanding First Nations Health Patterns in a Historical Context, in "Aboriginal Health Research and Policy: First Nations-University Collaboration in Manitoba," supplement to the *Canadian Journal of Public Health*. Volume 96, Supplement 1: S18.

[30] Ibid.

[31] Ibid.

[32] It is important to note that these are broad generalizations of the historical health of Aboriginals in Manitoba, and that experiences have varied in different communities

Government of Canada has been unable to provide health care that raises the health level of Aboriginal people to that of other Canadians.

The British North America (BNA) Act of 1867 conferred the responsibility of Aboriginal peoples and lands on the Government of Canada, simultaneously giving the provincial governments jurisdiction over health and social services[33]. This shared responsibility has resulted in years of complex intergovernmental relations regarding Aboriginal health.

Generally, the federal government has directed Aboriginal health policy, provided funding and delivered or overseen the delivery of health services to Aboriginal peoples. As revealed in the earlier statistics on the wide health gap, policy, funding and service delivery arrangements of the past have failed to adequately sustain or improve Aboriginal health to the point that it matches the condition of other Canadians.

Prior to 1945, Aboriginal health care was managed by the Department of Indian Affairs, which was officially created in 1880. This department proved ineffective, reflecting an extremely bureaucratized approach to health that was evident in their policies. For example, all medical officers had to consult with Indian agents before patients could be admitted to hospital. Approval from the departmental office in Ottawa had to be obtained before a patient could be evacuated by airplane, sent to a sanatorium or quarantined[34]. Clearly, this approach to health care was inefficient and an impediment to Aboriginal health.

The responsibility of Aboriginal health was shuffled several times throughout the 1900s. In 1945, Aboriginal health was transferred from DIAND to the federal

---

[33] Long and Fox, 244.
[34] Ibid, 245.

Department of Health[35]. In 1962, it was transferred again when seven separate service areas were joined under the Medical Services Branch (MSB) directorate. In 2000, the MSB was renamed the First Nations and Inuit Health Branch (FNIHB), which maintains control over Aboriginal health care and policy to this day.

Over the last 40 years Aboriginal health service delivery has evolved, providing more and better service to meet Aboriginal needs. However, this has failed to improve Aboriginal health enough to close the health gap between Aboriginals and other Canadians. There are very few active treatment hospitals in Aboriginal communities. Instead, nursing stations and health centers[36], where a doctor may be brought in only once or twice during a month, are the primary source of medical care for Aboriginal people living on reserves.

The 1979 Indian Health Policy outlined the federal government's new strategy for Aboriginal health care, which was essentially to improve the health of Aboriginal people and help them to generate and maintain this health on their own[37]. The need for increased levels of participation and self-determination was recognized in the 1980 Report of the Advisory Committee on Indian and Inuit Health consultation (Berger Report), which recommended that Aboriginal people be meaningfully involved in the design, management and control of health care services in their communities[38]. The 1983 Report of the Special Committee on Indian Self-Government (Penner Report) advised the federal government to establish a new relationship with First Nations recognizing their right to

---

[35] Ibid.

[36] Long and Fox, 246.

[37] Canada. Health Canada, *Ten Years of Health Transfer First Nation and Inuit Control*, http://www.hc-sc.gc.ca/fnih-spni/pubs/agree-accord/10_years_ans_trans/2_intro_e.html#Introduction (accessed 30 March 2008)

[38] Ibid.

self-government[39] and highlighting health as an important area to transfer to Aboriginal control.

By 1988, the federal government had developed a plan to address this issue called the Health Transfer Policy, which provided a framework for the shift of control of health services to Aboriginal people. This framework was rooted in the concept of self-determination in health[40], although government and Aboriginal groups may have had different definitions of control and self-determination. The result has been that over the last 15 years, responsibility for the administration of community based health programs has been transferred to many First Nations communities. The current state of Aboriginal health care has been influenced by federal control and self-determination and the thesis will now turn to an examination of current Aboriginal health policy, funding and program delivery arrangements.

Current Policy and Programming in Aboriginal Health

The First Nations and Inuit Health Branch (FNIHB) of Health Canada is currently responsible for the delivery of public health services on-reserves and in Inuit communities. FNIHB has offices in every province except in Atlantic Canada, which is represented by an Atlantic Region office due to the relatively small numbers[41] of Aboriginal peoples in this part of Canada. FNIHB provides drugs, dental and additional health services to status Indians and Inuit peoples. In principle, Aboriginal peoples who live off reserve or who do not have official Indian status, have access to the same medical services available to all Canadians, but as discussed later there are obstacles to them

---

[39] Ibid.

[40] Health Canada, *Ten Years of Health Transfer.*

[41] Canada. Health Canada. *First Nations and Inuit Health,* Website. http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index_e.html (accessed March 30, 2008).

accessing such services. The Branch provides primary care services on-reserves located in remote and isolated areas, where provincial health services are not available. These primary care services take the form of health centres or nursing stations[42]. Health Centers focus on basic public health principles, health promotion and health protection. Nursing Stations provide emergency and treatment services.

One of the difficulties of Aboriginal health care is the limited access to medical services faced by Aboriginal people. If a serious illness strikes a resident in a remote community they must be transported by medivac (airplane) to a hospital. This problem became a very public issue in 1999, when four First Nations chiefs in northwestern Ontario began a hunger strike to protest the poor level of health care in their region and invited the World Health Organization to tour the area. The Sioux Lookout Zone Hospital, which was run federally, was virtually closed in early 1999 due to a shortage of physicians and nurses, meaning that some 15,000 people had to travel hundreds of kilometers to receive basic health care services[43].

It is difficult to attract medical staff to these remote areas. In a report on the health status, socio-economic risk and health care use of the Manitoba population, 1992-93, it was determined that most of Northern Manitoba had relatively high health care needs but lacked sufficient physicians to meet these needs. This included the areas of Flin Flon, Norway House/Cross Lake, The Pas, Island Lake, Oxford House, and the remote communities served by Thompson area physicians [44]. The report also indicated that the

---

[42] Health Canada, *First Nations and Inuit Health*.

[43] Michael O'Reilly, "Hunger Strikers Protest First Nations Health Care", *Canadian Medical Association Journal,* Vol.160 Issue 11 (June, 1999).

[44] R.J. Currie. "Report Summary based on the report: Needs-Based Planning for Manitoba's Generalist Physicians" *MCHP website*. http://www.umanitoba.ca/centres/mchp/reports/reports_94-96/surdocs.htm (accessed January 2007).

province spent almost 50% more per Winnipeg child than per Northern child on physician services. This is surprising considering that the data indicates elevated need in the North. Likewise, 34% more was spent to provide physician services to Winnipeg adults than to adults in southern rural Manitoba, even though populations share a similar level of need[45]. This unequal distribution of physicians throughout the province obviously has a negative impact on the health of the many Aboriginal people who live in these remote areas.

FNIHB maintains the Non-Insured Health Benefits Program (NIHB), which provides medically necessary health-related goods and services, not covered by other federal, provincial, territorial or third-party health insurance plans, to about 779,943 eligible registered Aboriginal people[46]. These benefits are provided in addition to provincial insured health care programs and encompass drugs, medical transportation, dental care, vision care, medical supplies and equipment, crisis intervention and mental health counseling. However, the 1979 Indian Health Policy stated that uninsured benefits would rely upon "profession medical and dental judgment"[47], meaning that, as with any benefit program, there are limits and restrictions. There are some substance abuse treatment programs and preventative health programs designed specifically for Aboriginal peoples. Increasingly there is a traditional, holistic element included in community health programs. However, Aboriginal health care remains primarily allopathic and operates within a bureaucratized system that may not effectively address

---

[45] Currie, *Report Summary*.

[46] Canada. First Nations and Inuit Health Branch, *Benefits Information*, http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestation/index_e.html (accessed March 30, 2008).

[47] Canada. First Nations and Inuit Health Branch, *Non-Insured Health Benefits Program Annual Report 2005-2006*, http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna/2006_rpt/01_intro_e.html (accessed March 30, 2008).

the special health needs of Aboriginal peoples. Whatever the reasons, and they are undoubtedly numerous, health policies, funding and programming for Aboriginal people in Manitoba has not been sufficient to close the gap between the health of Aboriginals and other Canadians, an issue that is explored in the next section of the chapter.

The Health Gap

The health gap is explored through a review of health statistics[48], focusing on health issues of particular importance to Aboriginal populations, such as: infant mortality rate, high birth weight, STDs, tuberculosis, heart disease, stroke, injury, violent death, and suicide. An examination of the prevalence of Type II Diabetes among Aboriginal populations serves to demonstrate how health is closely associated with political, economic, social and environmental factors.

Demographically, Aboriginal people are younger than other Canadians. According to 2006 Census data the median age for Inuit (22 years old), First Nations (25 years old) and Métis (30 years old) was significantly lower than the median age for the non-Aboriginal population in Canada (40 years old)[49]. Children and youth (aged 24 and under) account for nearly one-half (48%) of all Aboriginal people, compared with 31% of the non-Aboriginal population.[50] This youngness is a health concern because it can be accounted for by the high birth rate and lower life expectancy of Aboriginals. The birth

---

[48] The statistics presented here have been gathered from a variety of reports and profiles compiled by organizations such as Health Canada, Statistics Canada, and the Manitoba Center for Health Policy. Most of these numbers refer specifically to ***registered*** First Nations people. The researcher has used the most recent health statistics available (often 2001 census data)

[49] National Aboriginal Health Organization, "Release of 2006 Census Data Continues to Tell the Story of First Nations, Inuit and Métis Health and Well-being, - http://www.naho.ca/english/newsReleases/01_15_2008.pdf (accessed March 30, 2008).

[50] Canada. Statistics Canada, "Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census" http://www12.statcan.ca/english/census06/analysis/Aboriginal/children.cfm (accessed March 30, 2008).

rate of Aboriginal people is 23 births per 1,000 population, which is twice the Canadian rate[51]. A high birth rate in and of itself is not a health problem but may be an indicator of low socio-economic status, which is in turn associated with poor health. Most underdeveloped countries also reflect high birth rates and lower life expectancies. As of 2000, the life expectancy of First Nations people was about 8 years less than that of all other Manitobans (males: 68.4 versus 76.1 years; females: 73.2 versus 81.4 years)[52].

Disturbingly, many First Nations health statistics highlight elevated rates of illness and disease. In 1999 the infant mortality rate was 8.0 deaths per 1000 live births, which is 1.5 times the Canadian rate of 5.5[53]. Almost twice as many First Nation infants (21%) were classified as high birth weight in 2003 [54]. The national rate was 13.1%. High birth weight may increase maternal and infant risk for complications and birth injuries[55]. This is a concern particularly for those Aboriginal mothers living in isolated and remote locations where access to health care professionals is limited. Aboriginal women tend to have children at a young age. In 2000, almost 20% of First Nation births were to teenaged mothers from 15-19 years of age[56], whereas only 6% of Canadian births occurred within the same age group[57]. Manitoba has the highest teen pregnancy rate in the country; 45% of the teenaged mothers in Manitoba are Aboriginal. This number is as high as 75% in

---

[51] Canada. Statistics Canada, *Census 2001,* http://www12.statcan.ca/english/census01/home/index.cfm (accessed March 30, 2007).

52 Patricia Martens, "Health and Healthcare Use of Registered First Nations People Living in Manitoba: A Population Based Study", (Manitoba Centre for Health Policy March, 2002) http://www.umanitoba.ca/centres/mchp/reports/rfn_pdfs.htm (accessed 2 April, 2008) 49.

[53] Canada. Statistics Canada, *Healthy Canadians: a Federal Report on Comparable Health Indicators*, 2002 http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2002-fed-comp-indicat/2002-health-sante2_e.html (accessed April 2, 2008).

[54] Canada. *The Well-Being of Canada's Young Children: Government of Canada Report 2006 (*Chapter 8) http://www.socialunion.ca/well_being/2007/en/chapter_8.shtml (accessed March 30, 2008).

[55] Ibid.

[56] Ibid.

[57] Ibid.

the Thompson region and 70% in Central Winnipeg[58]. Teenage pregnancies are a health concern because Aboriginal children are more likely to be raised by inexperienced or immature parents who may lack important parenting skills. Young teenage mothers also tend to have little to no income, meaning that more Aboriginal children are living in poverty, which can have serious implications for health[59].

The poor health of Aboriginals compared to the general Canadian population becomes obvious when examining the increased prevalence of a host of diseases, injuries and illnesses. Sexually Transmitted Diseases are more prevalent in the Aboriginal population, the First Nations rate of genital chlamydia being roughly 7 times the Canadian rate[60]. In 2000 First Nations had abnormally high rates compared with the general Canadian population for pertussis (2.2 times higher), rubella (7 times higher), and shigellosis (2.1 times higher), which are serious infectious diseases[61]. Tuberculosis is at least six times more likely to infect an Aboriginal person than any other Canadian[62]. Type II Diabetes is far more prevalent among the Aboriginal population and onset occurs at an earlier age. This has the side effect of increasing Aboriginal rates of heart disease and strokes. Smoking related diseases are common because 62% of First Nations people smoke (1997). This leads to a 40% higher chance that they will experience stroke and a 60% higher rate of heart disease[63]. All First Nations people up to the age of 65 are at

---

[58] Manitoba Aboriginal and Northern Affairs . *Report on Aboriginal People in Manitoba: 2000.* (Chapter 1: Demographics) http://www.gov.mb.ca/ana/apm2000/1/n.html (accessed April 2, 2008).

[59] Ibid.

[60] Canada. Health Canada, *A Statistical Profile on the Health of First Nations in Canada.* http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/stats_profil_e.html (accessed 2 April 2008).

[61] Ibid.

[62] Ibid.

[63] Ibid.

increased risk compared with other Canadians for suicide[64]. The leading cause of death for First Nations people aged 1 to 44 years is self-injury and suicide. After age 44, circulatory disease is the leading cause of death. According to the Potential Years of Life Lost (PYLL), a health status indicator that gives greater weight to deaths occurring at a young age, the PYLL for Registered First Nations people is much higher than the PYLL for all other Manitobans (2.5 times higher for males, 3 times higher for females), indicating that not only is there a higher mortality rate for registered First Nations, but also that proportionally, more young Aboriginal people are dying[65].

These disturbing statistics highlight the poor health of First Nations people. However, they should be examined in combination with non-medical determinants of health, determinants that are currently at least somewhat controlled by the federal government. The influence of non-medical determinants of health becomes particularly evident when examining the prevalence of chronic diseases such as Type II Diabetes among Aboriginal populations.

Type II Diabetes is an example of a chronic disease that affects Aboriginal peoples disproportionately. High rates of incidence and early onset of Type II Diabetes make it a serious health concern for Aboriginal people. According to the 2001 Aboriginal Peoples Survey, the rate of diabetes in the Canadian Aboriginal Population was at approximately 7%, compared with the Canadian rate of 2.9%. Diabetes was the fifth most prevalent health problem among the non-reserve population of Aboriginal

---

[64] Health Canada, *A Statistical Profile on the Health of First Nations*, 21.

[65] Manitoba Centre for Health Policy, *Health and Healthcare use of Registered First Nations People Living in Manitoba: A Population Based Study* http://www.umanitoba.ca/centres/mchp/reports/pdfs/rfn_pdfs/rfn_ch04.pdf (accessed 2 April 2008) 50.

adults.[66] There is evidence that the rate of diabetes on reserve is even higher. Type II Diabetes is increasingly common among Aboriginal women and children. Aboriginal populations have more severe cases of diabetes at diagnosis, and have a higher rate of complications from Type II Diabetes than the Canadian population as a whole[67].

Health Canada defines Type II Diabetes as non-insulin dependent diabetes, typically observed after the age of 40 years. It is characterized by a resistance to insulin and often exacerbated by excess weight. The pancreas cannot produce enough insulin to compensate, which can result in various health complications[68]. These complications include amputations, loss of eyesight, hypertension, kidney disease, heart disease and stroke.

Type II Diabetes has several causes and associations of significance to Aboriginal populations. According to the Royal Commission on Aboriginal People, diabetes was rare in pre-contact times[69]. Recently, the incidence of Type II Diabetes in Aboriginal populations has grown exponentially. The Aboriginal Peoples survey of 2001 found that 8.3% of non-reserve Aboriginal adults reported that they had been diagnosed with Type II Diabetes, compared with 5.3% in 1991. The rate in the total Canadian population was 2.9%[70]. Some scientists theorize that Aboriginal ancestry is a risk factor for Type II Diabetes. This theory proposes that dramatic changes in lifestyle in the century and a

---

[66] Canada. Statistics Canada, *Aboriginal Peoples Survey 2001* http://www.statcan.ca/english/freepub/89-589-XIE/89-589-XIE2003001.pdf (accessed 3 April 2008) 15.

[67] Statistics Canada, *Aboriginal Peoples Survey 2001,* 15.

[68] Canada. Health Canada, *Diabetes Among Aboriginal (First Nations, Inuit and Métis) People in Canada: The Evidence* http://www.hc-sc.gc.ca/fnih-spni/pubs/diabete/2001_evidence_faits/intro_e.html *(*accessed 3 April 2008*).*

[69] *RCAP Report* ,Vol. 3.

[70] Statistics Canada, *Aboriginal Peoples Survey*, 2001.

special genotype, allow Aboriginal people to store energy from food more efficiently. This has lead to higher levels of obesity and diabetes[71].

> Due to the nomadic lifestyle and feast/famine cycles of their ancestors, Aboriginal people in Canada are likely to be predisposed to store energy from the diet very efficiently. The adoption of a market diet high in energy, saturated fat and simple sugars, along with an increased tendency toward sedentary lifestyles and reduced physical activity, leads to a rise in the prevalence of obesity and subsequent diabetes. [72]

Aboriginal people, especially those who live on reserves, may find it difficult to eat healthy foods because of the cost of food. Income levels on reserves are less than half that of other Canadians and unemployment is rampant[73]. However, the cost of food on isolated reserves is astronomically high. Food must be brought in by plane or hauled in by truck on the winter road. Winter roads are temporary passageways constructed over frozen lakes and streams and they are passable only in the coldest months of the year. In the winter of 2005/2006, mild temperatures prevented the construction of winter roads to many communities, driving the price of groceries even higher. In January 2006, in the community of Island Lake, a four liter of milk cost $20.[74] Prices on healthy, perishable foods such as fresh fruit and vegetables are especially high. As a result, the diets of on-reserve Aboriginals tend to include a lot of lower-priced 'junk' food, which are high in saturated fat and processed sugars. This unhealthy diet increases their risk for developing Type II Diabetes. Alcohol abuse and high rates of smoking, both prevalent in Aboriginal populations, are also associated with Type II Diabetes[75].

---

[71] Canada. Health Canada, *Diabetes Among Aboriginal (First Nations, Inuit and Métis) People in Canada: The Evidence* http://www.hc-sc.gc.ca/fnih-spni/pubs/diabete/2001_evidence_faits/intro_e.html. (accessed 3 April 2008).

[72] Health Canada, *Diabetes Among AboriginalPeople.*

[73] Canada. Health Canada, *A Statistical Profile on the Health of First Nations in Canada* http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/stats_profil_e.html (accessed 3 April 2008) 64.

[74] "Kids' Fund Sends Food North," *Winnipeg Free Press*, 25 January 2006, B3.

[75] *RCAP Report,* Vol. 3.

Many non-medical determinants of health are factors that may lead to increases in complications from Type II Diabetes among Aboriginal populations. Patients on isolated reserves have limited opportunities to see physicians. This may result in late diagnosis of the disease, when it has already advanced to a more dangerous form. Patients may misunderstand or disregard the physician's directions for treatment and care. This non-compliance is likely a result of culturally inappropriate approaches to treatment and care[76]. A person's cultural values and experiences may shape the way they view their disease or approach treatment. For example, being overweight may be viewed as a sign of status or wealth[77]. Many Aboriginal people are unfamiliar with the doctor-recommended foods and the methods of preparation. As discussed above, these foods are often unavailable in isolated communities or very expensive. A more culturally sensitive approach to treatment and care could address some of these issues[78]. Although primary health programs that try to encourage healthier eating and lifestyles are becoming more common, they have not yet succeed in addressing this serious problem.

The isolation of many reserves is a critical issue in the field of Aboriginal health. A central difficulty is that there are virtually no doctors who are permanent residents on reserves in Manitoba[79]. This problem becomes evident through the comparison of health services available in remote northern communities and services available in southern Manitoba. For example, Oxford House and Gimli are communities of similar size in terms of population. Oxford House is a northern reserve community with a population of

---

[76] *RCAP Report,* Vol. 3.
[77] Ibid.
[78] Ibid.
[79] Manitoba Centre for Health Policy, *Comparative Indicators of Population Health and Health Care Use for Manitoba's Regional Health Authorities, 1999* http://www.umanitoba.ca/centres/mchp/reports/pdfs/rha.pdf (accessed 3 April 2008) Appendix 2, 131.

1947 people[80]. The community has a nursing station run by Health & Welfare Canada, which is under the FNHIB. The nursing station employs five nurses, an administrative clerk, a maintenance person and a janitor. Acute care clinics as well as public health programs are operated out of the nursing station. Three community health workers, employed by the Band, focus on providing primary health care through illness prevention initiatives and health education. Part-time care is provided to the people from other health professionals at specific times. A doctor is available only once every two weeks. Pediatricians and optometrists fly in to Oxford House two or three times a year, dentists are available for two weeks on a monthly basis and a psychologist flies in twice a month. A branch of the Native Alcohol and Drug Abuse Program has offices in the community and employs two counsellors who are responsible for providing substance abuse counseling, suicide prevention, marriage counseling and court-ordered supervision services. Mental Health Services and all other health related issues are referred to Winnipeg, Thompson, or Selkirk, MB for care and treatment[81].

In comparison, Gimli, a town located an hour north of Winnipeg by car, has a population of 1,657[8283]. As of 2005, five doctors worked and lived in Gimli[84]. There is a newly renovated Community Health Centre (GCHC) formerly known as the Johnson Memorial Hospital which provides a variety of services and programs including:

---

[80] Statistics Canada, *Census 2006,* http://www.gov.mb.ca/asset_library/en/statistics/north.pdf (accessed 3 April 2008).

[81] Community Futures Kitayan, *Oxford House First Nation* http://www.kitayan.ca/website/pages/oxford_house.html (accessed 3 April 2008).

[82] Statistics Canada, *2001 Census.* http://www12.statcan.ca/english/census06/data/trends/Table_1.cfm?T=CSD&PRCODE=46&GeoCode=18031&GEOLVL=CSD (accessed 3 April 2008).

[83] The medical services in the town of Gimli also service the residents of the RM of Gimli, which has a total population of 5,797, according to the 2006 census. It also services the many tourists who come to the region during the summer and on the weekends.

[84] "Gimli Doctors Return to Emergency On-call Rotations," *Interlake Spectator* November 2005, http://www.interlakespectator.com/story.php?id=194449 (accessed 3 April 2008).

Emergency / Out Patient Department, Diagnostic Imaging and Lab Services, Chemotherapy Program, EMS / Ambulance, Palliative Care, Acute Care, Physiotherapy Services, Occupational Therapy Services, Adult Day Program and Pharmacy Services[85]. The Gimli Community Health Office provides a full range of health services including public health, mental health and home care to all residents within the community. Gimli also has two dentists, an optometry clinic, a denturist, a clinic offering physiotherapy and massage, a veterinarian and two drug stores[86]. Gimli offers a Handi-Van service and a meals-on wheels program, to help the elderly and infirm. The hospital even has a "Healing Garden" with a fountain, fire-pits and seating areas, aimed at providing a stress-free place of healing for those in care at the centre and those in the community.

Illustration 1:
Gimli Hospital, September 2008

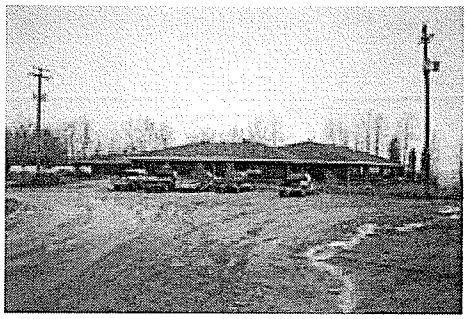


Illustration 2:
Oxford House Nursing Station, April 2008

The vast difference between health services available in Gimli and Oxford House demonstrates the unbalanced nature of health care services in Manitoba. Unfortunately, limited access to medical services contributes to the poor health of Aboriginal people. Aboriginal people may delay necessary medical treatments because they do not wish to leave their communities. Serious operations and treatments require reserve Aboriginals to

[85] Town of Gimli, *Health Services* http://www.gimli.ca/services/services_det.asp?ID=16 (accessed 3 April 2008).

[86] Town of Gimli, *Health Services.*

be transported by plane to the nearest hospital, often hundreds of kilometers away. The delay of these treatments can lead to very serious complications. The RCAP report states, "Fly-out patient programs are expensive and disruptive to patients and their families, and they work only when accurate local diagnosis can be depended on. Fly-in expertise is irregular, unreliable, and sometimes insensitive to local cultures and conditions."[87]

It is evident that health is associated with numerous factors related to lifestyle, culture and environment. These factors have their roots in political, social, historical and economic spheres. Health can be significantly effected by environment, location, housing, economic status and education. According to the 2006 census, First Nations have less education[88] than other Canadians. One in three Aboriginal (First Nations, Metis and Inuit) persons has not completed high school. Only 8 % of Aboriginal people have a University degree, whereas 23% of Canadians have a university degree.[89] Educational levels are particularly low among the registered First Nations population. This lack of education has been correlated with increased unemployment. In 2006 the First Nations unemployment rate was 13.2%, more than twice as high as the Canadian rate of 5.2%[90]. Income levels are low because unemployment is high. In 2001 First Nations income levels on reserve were only half that of other Canadians[91]. This statistic is significant

---

[87] RCAP *Report,* Vol 3.

[88] As measured by educational attainment indicators such as secondary school completion or acceptance into university.

[89] Canada. Statistics Canada, *Educational Portrait of Canada, Census 2006* (Catalogue no. 97-560-X, p19) http://www12.statcan.ca/english/census06/analysis/education/pdf/97-560-XIE2006001.pdf (accessed 4 April 2008).

[90] Canada. Statistics Canada, *Canada's Changing Labour Force, 2006 Census: The provinces and territories,* http://www12.statcan.ca/english/census06/analysis/labour/ov-cclf-26.cfm (accessed 4 April 2008).

[91] Canada. Indian and Northern Affairs Canada, *Post-Secondary Education and Labour Market Outcomes Canada, 2001: Average and Median Incomes* http://www.ainc-inac.gc.ca/pr/ra/pse/01/pt2-9_e.html (accessed 4 April, 2008).

because Canadians with low incomes are far more likely to experience poor health than Canadians with high incomes[92].

A clean environment is essential to health, and many reserves lack proper waste disposal and treatment facilities. Overcrowded and inadequate living spaces are common. Problems such as no electricity or running water, substandard construction, toxic mould and need of major repairs can result in chronic sickness and stress for many Aboriginal people[93]. For example, overcrowding can account for the higher rate of tuberculosis among First Nations. According to the 2001 census about 12% of homes in First Nations communities were over crowded, compared with 1% in the rest of Canada[94]. As of 2005, out of almost 96,800 houses in First Nation communities, more than 21,200 (21.9%) required major repairs and about 5,500 (5.7%) needed to be replaced[95].

Other health issues prevalent in First Nations communities are alcohol and substance abuse, violence, and domestic abuse. On February 27 2001, the then national chief of the Assembly of First Nations, Matthew Coon Come remarked on the problem of alcoholism in First Nations communities adding that Fetal Alcohol Syndrome rates among Canadian First Nations are twenty-five times the world average[96]. One study in British Columbia reported that eighty-six percent of Native respondents had experienced

---

[92] Canada. Statistics Canada. *Health of the Off Reserve Aboriginal Population* (The Daily, Tuesday August 27, 2002) http://www.statcan.ca/Daily/English/020827/d020827a.htm (accessed 4 April 2008).

[93] Assembly of First Nations, *First Nations Housing Action Plan*, October 2005 http://www.afn.ca/cmslib/general/Housing-AP.pdf (accessed 4 April 2008) 5.

[94] Indian and Northern Affairs Canada, *First Nations Housing*, http://www.ainc-inac.gc.ca/pr/info/info104_e.html (accessed 4 April 2008).

[95] Ibid.

[96]" When it come to alcohol, it's time to start discriminating against Aboriginals", *Report Newsmagazine* (Alberta Edition,Vol.28 Issue 8 April 2001), 30.

family violence[97]. Gasoline sniffing is a devastating problem, especially among Aboriginal children. A 1986 study commissioned by an association of twenty-five bands in Northern Manitoba, discovered that 70 percent of all Aboriginal children in northern Manitoba had sniffed gasoline[98].

One does not have to look far to find plausible explanations for these disturbing statistics. The Canadian government has a long history of mistreating Aboriginal peoples, culturally and politically. Marginalization, paternalism and discrimination, typical of colonial relationships, have had far reaching effects on all aspects of Aboriginal lives. Colonization in Canada marginalized Aboriginals by taking their traditional lands and forcing them onto remote reserves. This colonization was accompanied by the atrocious era of Residential Schools, which were an attempt to assimilate Aboriginal cultures and people into Canadian Society. Barman writes, "By taking children away from the old ways and civilizing them into European ways , so the argument ran, "the Indian Problem" would be solved."[99]

The Government of Canada was motivated by commonly accepted (at the time) paternalistic notions of morality and prejudiced ideas of favourable lifestyles. Through the residential schools, they systematically set out to destroy Aboriginal language, culture and way of life. For example, Menno Boldt notes:

> Under the compounded impact of forced cultural and institutional assimilation, economic dependence, and isolation, Indian cultures have undergone a process of cultural degeneration or 'deculturation'; that is, many traditional social systems, normative patterns, and practices of surviving and living have disappeared as a

---

[97] Fox and Long, 250.

[98] GeofferyYork, *The Dispossessed: Life and Death in Native Canada.* (Toronto: McArthur and Co., 1990), 10.

[99] Barman, 273.

> result of government repression....The loss of consequential traditional cultural traits and patterns, without replacement by new functional forms , has undermined the Indians' means for maintaining social order within their communities.[100]

Residential schools forced children away from their homes and families and into an environment where they were taught that their culture was wrong and immoral. They were not allowed to speak their own language and many Aboriginal children faced sexual, emotional and physical abuse in residential schools[101]. This abuse, in combination with several generations of Aboriginal peoples whose self-image was purposely decimated by the federal government has resulted in social dysfunction including addiction, violence, suicide and poverty, which all lead to poor health[102]. Many of these negative health determinants are perpetuated by low self-esteem, which may be connected to a sense of powerlessness to change the nature of life on reserves.

Conclusion

The statistics examined in this chapter reveal that Aboriginal people suffer from radically poor health compared to other Canadians. Socio-economic factors affect their health, and these factors have their roots in historical events and political prejudice. Life on-reserve is often difficult. Unemployment, alcoholism, domestic violence and sexual abuse are rampant. The question remains, why has the Canadian healthcare system failed to usefully address these problems despite official awareness of the issue for many decades? Are the health care services available to Aboriginal people substandard to those offered to other Canadians, or are there other explanations for these dismal statistics such as limited access, remote communities, or culturally insensitive policy and

---

[100] Menno Boldt, *Surviving as Indians: The Challenge of Self-Government*, (Toronto: University of Toronto Press, 1993), 174.

[101] York, 30.

[102] York, 177.

administration? Almost a decade ago, the RCAP proposed a major examination of these issues and offered recommendations to improve the health situation of Aboriginal people, but the health gap remains prevalent to this day. The next chapter examines factors in public policy, health policy and Aboriginal politics that have likely affected the impact of the RCAP and its recommendations regarding health.

Chapter Three:

The Influence of Public Policy, Health Policy and Aboriginal Politics

The impact of the RCAP on Aboriginal health in Manitoba is best understood in the context of three key realms in Canadian politics: public policy, health policy and Aboriginal politics. This chapter outlines the important themes and issues within these realms that may have influenced the impact of the RCAP on the Aboriginal health sector in Manitoba. It will identify several important cross-cutting issues that may play a role in the substandard level of Aboriginal health in Manitoba, and form a part of the problem set inherent to adopting the changes in policy and programming recommended by the RCAP. Representative writings are consulted and quoted to support the issues identified in the conceptual framework set out in Chapter One.

Public policy theory will be examined with specific focus on the role of royal commissions in policy change. In recent years, royal commissions, task forces and advisory committees have become significant mechanisms of the health governance network[103]. According to Paul Thomas in his article, *The Challenges of Governance, Leadership and Accountability in the Public Sector*, health governance is an adaptive process that occurs at many levels and consists of the actions of multiple organizations. It implies a broad concept of shared authority and financing between governments, various areas of the health care system and other major policy stakeholders[104]. The political relevance of health issues and the sense of emergency that permeates the field have motivated governments to turn to outside bodies for policy advice. Although it is nearly

---

[103] Carolyn Hughes Tuohy, "The Costs of Constraint and Prospects for Health Care Reform in Canada," in *Health Affairs: The Policy Journal of the Health Sphere* (Accessed 1 August 2008) available from http://content.healthaffairs.org/cgi/content/full/21/3/32; Internet.

[104] Thomas, 127.

impossible to measure the direct impact of royal commissions on policy, it is useful to analyze their important role in the evolution of policy and programming.

Neil Bradford, a leading scholar on Canadian policy innovation, claims that throughout history, royal commissions have played a crucial role in introducing innovative policy ideas and fostering Canadian social learning about national priorities and goals[105]. Examining three influential royal commissions throughout Canadian history, Bradford finds that the processes and final products associated with royal commissions have generated new forms of policy activity. Royal commissions have been able to trigger policy change where other actors and systems, including brokerage political parties, interest groups, bureaucrats and intergovernmental relations have failed to do so. Bradford maintains that national policy is ultimately created in 'intermediate-level institutions' of social learning that connect state and society. This social learning involves the spread of new ideas and information, which ultimately allows governments to make decisive policy decisions. Social learning networks are a key part of royal commissions – they are the institutionalized networks that connect individuals and organizations and ultimately generate new and innovative policy ideas. According to Bradford, this is where royal commissions have the advantage over other policy organizations. Royal commissions have no party ties and they have the freedom and in fact, the mandate to consult multiple groups, people, experts and organizations. The assumption is, that wide spread consultation of diverse groups and people may result in better policy solutions and promotion of social learning about the policy issue[106].

---

[105] Neil Bradford, *Commissioning Ideas: Canadian National Policy Innovation in Comparative Perspective*, (Toronto: Oxford University Press, 1998), 159.

[106] Ibid,16.

The question remains, why do certain ideas have influence while others fail to gain the necessary support to impact policy? Bradford says that the translation of ideas into policy is dependent on economic, administrative and political viability. He draws on the work of Robert Keohane and Judith Goldstein who proposed that ideas could influence policy outcomes through three pathways[107]. The first is a political pathway whereby ideas influence policy outcomes by providing 'road maps' that clarify interests and goals for actors. The second is a societal path whereby new ideas reveal common ground that allows for strategic alliances among actors. The third is an administrative pathway through which ideas may become institutionalized in government policy structures[108]. Bradford also draws on the work of Peter A. Hall, who says that in order to complete these pathways and manifest into policy, these ideas must be economically, politically and administratively viable. Economic viability refers to the extent to which new ideas are germane, or are perceived to be germane, to solving the country's economic problems. Clearly, this test of relevance depends heavily on the theories and norms used to judge new ideas, including society's widely accepted beliefs about the structure of the economy, various international factors and the boundaries that these place on national policy innovation[109]. Bradford also writes that the viability of new ideas can be enhanced if the ideas launch intellectual movements that further develop the ideas to the point of challenging the basic theoretical premises of the accepted policy model[110].

Administrative viability centers on the nature of the ideas and how they harmonize with the administrative biases of the officials responsible for

---

[107] Bradford,19.
[108] Ibid.
[109] Ibid.
[110] Ibid,20.

implementation[111]. At its core, determining administrative viability means assessing the feasibility of realizing these ideas, which is dependent on the current capacities of the state. This requires a close look at the relationships between departments and central agencies, banks and finance ministries, resources and levels of expertise[112]. Political viability refers to the fact that new ideas must have advocates among the political elite and powerful interest groups. According to Bradford, if a new idea has economic, administrative and political viability it will likely acquire a lasting influence. Therefore, a royal commission can play two key roles in the policy process. It can generate innovative policy ideas and then create social learning about these ideas, the issues and the possible solutions. As this social learning takes place, it will be determined whether or not these new policy ideas are viable and will be adopted in public policy. One complaint about royal commissions is that commissioners do not usually stay around to lobby for their ideas; they go back to their usual occupations and there is less pressure to act on the recommendations. The following section examines the specific area of health policy with reference to the framework of public policy and royal commissions in policy change.

Health policy in Canada involves many actors including health professionals, provincial and federal government actors, and others. Changes in health policy are usually incremental or evolutionary due to the complex nature of the field and the sensitive nature of the issues.

> In the health field, it is artificial to think of change like a switch which is either off or on. Depending on the focus of the analysis, there will always be changes taking place and part of the leadership challenge is to recognize and to coordinate the interactions among decisions on different levels, as well as horizontally within health and with other policy fields.[113]

---

[111] Bradford, 20.
[112] Ibid.
[113] Thomas, 124.

Given the slow nature of change in the field of health policy, it would be naïve to believe that the recommendations made by the RCAP would be rapidly incorporated and implemented in Canadian health policy. Certain theories contribute to our understanding of the challenges of implementation in the health policy field. According to Kingdon's (1995) model of policy change, three streams – the problem stream, the policy stream and the politics stream – meet to force issues on to the policy agenda[114]. When these three streams merge, major policy changes are more likely to occur. There is debate and controversy about the relevance and need for modification of the Kingdon model to the Canadian political system, given that it was developed based on the study of policy-making in the USA with its system of separation of powers, checks and balances and often divided government at the national level with different parties controlling the Presidency and Congress.

It could be argued that the concentration of authority and power in Canada's cabinet- parliamentary model of government would seem to hold the potential for more decisive and bold action than in the highly dispersed policy–making process in the USA. In the Canadian context a Prime Minister or Premier can move an issue on to the agenda of government, insist that it be given a priority in the bureaucracy, and if legislative action is required ensure that a bill is passed, especially when there is a majority government. In other words, there is less requirement for a fortuitous combination of circumstances (the three streams converging) for a window of opportunity to open. In effect, the First Minister has more freedom to open the window. Governments in the

---

[114] John W. Kingdon, *Agendas, alternatives, and public policies* (2nd ed.). (New York: Longman, 1995).

Canadian context often use Royal Commissions to prepare the ground for action and use the report as a defining moment to set forth a new direction. However, health policy making involves federal-provincial divisions of responsibility and cross cutting policy issues which transcend the boundaries of several departments. It also involves the need to gain the consent of increasingly more autonomous and demanding Aboriginal organizations and the difficult reality of a cultural divide that exists between mainstream society and its governments and the diverse societies and organizations which comprise the Aboriginal population. For these reasons, the Kingdon model still works as a good theoretical fit for this discussion.

In the case of health policy, rapid changes are less likely because there are multi-leveled policy systems involved. There are "big" policy windows of opportunity that occur when the three streams converge at the national level and "little" policy windows of opportunity when the streams converge at the local level. Therefore, there are limited windows for major policy changes, a fact which is extremely important for the interpretation of the Canadian health policy system[115]. This may explain why even ten years after the release of the RCAP report, many of its recommendations have not been implemented.

Aboriginal Politics/Policy

Having examined the role of public policy and health policy in relation to the impact of the RCAP it is helpful to explore the role of Aboriginal politics and policy. Today, Aboriginal politics focuses on a wide range of areas including land claims and self-government, nationhood and inherent rights. Political and social issues of particular

[115] Thomas, 122.

importance to Aboriginal groups include women's rights, child poverty, domestic violence, education, justice and health.

Prior to the arrival of Europeans, Aboriginal peoples in Canada had very effective political institutions that successfully kept order and fostered social harmony[116]. As Europeans gained more control over North America, Aboriginal people were subjected to plagues, aggressive attempts at Christian conversion and overwhelming waves of European settlement. The focus of Aboriginal leaders became geared toward preserving sovereignty and lands. Ultimately, the goals of Aboriginal political leaders and groups have changed very little over the last hundred years. They are still centered on demands for nation-to-nation negotiations between Aboriginal groups and the Canadian State. Aboriginal people seek ownership and use of their traditional lands along with a legal and practical recognition of their right to govern themselves[117].

In the 1960s the national Indian movement mobilized Aboriginal people into political action. It was a time of social change, and as the civil rights movement gained strength in the United States, Aboriginal people became increasingly dissatisfied with their lot in society. The first national political Indian organization was founded in 1968, called the National Indian Brotherhood (NIB)[118]. This groundbreaking organization finally managed to unite hundreds of thousands of Indians across Canada and give them a single voice. The NIB played an important role in protesting the 1969 White Paper, which proposed to eliminate the Indian Act and the special relationship established

---

[116] Peter McFarlane, " Aboriginal Leadership," in *Visions of the Heart: Canadian Aboriginal Issues*, ed. David Alan Long and Olive Patricia Dickason (Toronto: Harcourt Brace & Company Canada Ltd., 1996), 117.

[117] Ibid, 142.

[118] Ibid, 136.

between Aboriginal people and the Canadian State[119]. This was a turning point in Aboriginal politics, and Aboriginal people and groups began to demand recognition of their special status and their right to self-determination.

In the 1970s Canadian Aboriginal leaders took their plight to the international level, seeking allies with similar histories of oppression to join them in their quest to improve the social, economic and political situation of Aboriginal people[120]. In 1975 Canadian Aboriginal leaders helped establish the World Council of Indigenous Peoples and the Inuit Circumpolar Conference[121]. In the early 1980s, NIB decided to change its structure in order to diffuse mounting tensions within its provincial sub-organizations. Thus, the Assembly of First Nations (AFN) was born, and it was made up directly of the 600 or more band chiefs, each with an equal say in decision-making. The AFN is the primary national Aboriginal political organization and it has been active and growing ever since its inception. On the provincial level there are also Aboriginal political organizations. In Manitoba, the Assembly of Manitoba Chiefs (AMC) exists to further the political objectives of Aboriginal people. The AMC is the provincial wing of the AFN, however one does not report to the other. They exist as separate but related organizations that are presumably purely political in nature. AMC has two sub-groupings; Manitoba Keewatinook Ininew Okimowin (MKO) which represents 27 northern bands, and the Southern Chiefs, which represents the rest of the bands, excluding a few that do not wish to be associated with either organization. Having identified these organizations it is now

---

[119] Boldt, 66.

[120] *The Canadian Encyclopedia,* "Native People, Political Organization and Activism", http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=A1SEC824984 (accessed 5 April 2008).

[121] Ibid.

important to explain the difference between groups such as the AMC and Tribal Councils.

Tribal Councils are supposedly non-political service delivery organizations. They tend to be governed by a council of chiefs in the tribal area. Tribal Councils were originally set up by Indian Affairs during the 1970s and 80s when the federal government wanted to eliminate regional offices and downsize the bureaucracy. For example, for many years Indian Affairs had a regional office in Thompson that was responsible for service delivery to the bands. Now, the Keewatin Tribal Council (KTC) receives funding from Indian Affairs in order to look after service delivery to the bands and for no other purpose. However, the Tribal Council often feels pressure from its members and communities to play a representative and lobbyist role, in order to influence policy that affects Aboriginals. This can create burnout, overwork and excess expectations for the members of the Tribal Council[122].

The political organizations experience a similar but reverse problem. They receive a small amount of funding to facilitate their political representation through lobbying. This is not nearly enough money to achieve their goals, so the political organizations seek to become service delivery organizations in order to have access to other funds. This can create tensions between the tribal councils and Aboriginal political organizations. It really becomes tricky to find the right words to describe the organizations on different levels. The choice seems to be mainly between political and governmental. AFN may be more political than governmental, because it does not actually deliver programs –at least not many. On the other hand, the MKO and the southern chiefs have argued for regional service delivery and could be seen as both political and governmental. The band councils

[122] Bruce Arnason, interview by author, Gimli, Manitoba, January 11, 2007.

are elected in local communities and run the operations of on-reserve services. At the end of the day, there is political content involved with all the organizations. Calling oneself a "government" may reinforce the message that First Nations are outside of the constitutional order (based upon history, treaties, inherited Aboriginal rights) and approach the Government of Canada on a nation-to-nation or government-to-government basis. In other words, Aboriginal organizations do not want be seen as just another pressure group.

In addition to Aboriginal political organizations, Aboriginal Policy Agencies play an important role in Aboriginal politics and policy change. Federal and provincial government departments for Aboriginal affairs have contradictory mandates stemming from two different policy communities, which results in "double identities"[123]. They act as Crown negotiators with Aboriginal groups over issues such as land claims and self-government, while at the same time developing government social policies that affect Aboriginal people. These roles are complex and contradictory because Aboriginal Policy agencies must act as both external negotiators and internal coordinators or advocates. In the case of INAC, it is expected to act in the best interests of both the federal government and the Aboriginal people; a task that may be impossible.

Ultimately, Aboriginal politics is an important factor to consider in the analysis of the perceived impact of the RCAP on Aboriginal health, health services and health policy. The complex nature of the Aboriginal political, service delivery and policy making organizations and their often conflicting mandates can explain why it takes so long for policy and service delivery to change or improve. The issues of utmost political

---

[123] Jonathan Malloy, "Double Identities: Aboriginal Policy Agencies in Ontario and British Columbia", *Canadian Journal of Political Science* 34, no.1(2001): 131.

importance to Aboriginal groups- land rights, and the right to self-government, may be perceived as conflicting with at least two basic goals of the Canadian state: to maintain unity and sovereignty. There is a void of understanding in mainstream Canadian society and within the political and bureaucratic elite of what self-government and Aboriginal control over lands and resources would mean for the rest of Canada. So long as this gap in understanding exists, it seems unlikely that Aboriginal interests and Canadian interests will ever be fully reconciled. Considering that Kingdon's model for policy change requires three streams (the problem stream, the policy stream and the politics stream) to meet, it is easy to understand why change is both rare and exasperatingly slow.

Although there is general acknowledgment among Aboriginal groups, the Canadian State and the Canadian population at large, that the health status of Aboriginal people in Canada is unacceptably poor, it seems that policy and services have been slow to adopt the changes necessary to address the grave situation. The RCAP officially recognized the health gap and identified the problem and the need to address it. However, royal commissions tend to review policy[124] and offer innovative policy ideas, not actively change it. The field of health policy is very complicated with many actors, networks, and organizations. As such, change is incremental, evolutionary and slow. Aboriginal politics and policy are also convoluted with various organizations playing dual and sometimes conflicting roles. Self-determination and land rights may be perceived as incompatible with the goals of the Canadian state, making it very difficult to realize the political, policy and service delivery changes that Aboriginal groups seek. According to Kingdon's model, the problem stream, the health policy stream and the Aboriginal politics stream all have to converge to create a window for policy change. The process of

[124] Thomas,127.

the Kelowna Accord probably illustrates how the support of a Prime Minister in resolving Aboriginal issues can speed up the process of policy making and create the potential for more dramatic change. Of course, a change in government and a new Prime Minister can mean a reversion to the normal incremental style of policy making. Kelowna is seldom talked about today. Keeping this in mind throughout the thesis will help in understanding the perceived impact or lack of impact of the RCAP on Aboriginal health, health services and health policy.

Cross-cutting Issues: Culture, Structure and Sovereignty

Having examined the history of Aboriginal health policy and programming, the shocking nature of the health gap, the non-medical determinants of health and the roles of public policy, health policy and Aboriginal politics, it is necessary to identify and discuss certain cross-cutting issues that appear in all discussions of Aboriginal health. Cultural issues, structural problems, resources and sovereignty[125] are some of the issues that will be explored below.

Culture

The traditional Aboriginal world-view is vastly different from the world-view of the Western Europeans that colonized North America. Although not all Aboriginal people hold traditional beliefs, understanding this cultural difference may be helpful in identifying some of the reasons why Canada's health policy and programming has been unable to close the health gap. Culture is a major factor in public policy, health policy and Aboriginal politics.

---

[125] Sovereignty refers here to both the sovereignty of Canada and the sovereignty of Aboriginal groups and people.

Menno Boldt, a leading scholar on Aboriginal issues, explains that cultures represent ideas about the purpose, value, and meaning of life[126]. For the Aboriginal people in Canada, these ideas come from philosophies and principles that the Creator communicated to their ancestors. The philosophies stress the importance of social and economic justice, equality, communalism, universal participation in decision-making, and a holistic concept of the world[127]. This holistic concept involves spiritual and balanced relationships with the land and all forms of life. It extends to health, meaning that wellbeing is related to emotional, spiritual and physical harmony. The holistic approach to medicine was not respected by the Europeans who arrived in North America. During the time of colonization, the prevailing worldview ranked cultures and people hierarchically, placing modern, developed European nations in high esteem and viewing Aboriginal peoples and cultures as primitive[128].

Colonization introduced the allopathic, or biomedical approach to health to Canada's Aboriginal people. This approach is illness-focused and characterized by observation and assessment. It does not emphasize the relationship between physical symptoms and emotional and spiritual health. Holistic methods of healing remain important to many Aboriginal people, but they are neither embraced nor well provided for within the current Canadian healthcare system. Naomi Adelson addresses this issue in a synthesis paper about health disparities in Aboriginal populations in Canada:

> Too often a narrow definition of health permeates the literature whereby programs and resources respond almost exclusively to an individual's departure from health (i.e. disease) and thus neglect the underlying constituents of either health or ill-health. Cultural differences in how we come to understand what health means,

---

[126] Boldt, 182.
[127] Ibid, 183.
[128] Curtis Cook and Juan Lindau, *Aboriginal Rights and Self-Government* (Montreal:McGill-Queens University Press, 2000), 42.

> economic conditions, living and social conditions, and one's level of education are all elements that must be addressed in concert with health care priorities and initiatives if we are to understand and effectively take on the formidable task in reducing health disparities and promoting equity in the Aboriginal Canadian population. [129]

The current health care system does not fit within the traditional world-view of Aboriginal peoples. The impersonal nature and focus on cost-minimization of the current health care system and bureaucracy clashes strongly with important values inherent to traditional Aboriginal cultures. The biomedical approach focuses on a patient who is diagnosed and who then undergoes treatments prescribed to him/her by the doctor. This could be reminiscent of other power imbalances regarding Aboriginal people in Canada[130].

In contrast, the Aboriginal model of wellness relies on a holistic understanding of the individual and their physical, emotional and spiritual state. This includes an examination of how the patient connects and fits with his or her family and community.[131] For the most part, this model is not incorporated into the biomedical environment of the Canadian health system. A holistic approach to healing may in fact, more effectively address the underlying non-physical determinants of health that effect Aboriginal communities. Most medical services available to Aboriginal people are administered by white people with an approach characterized by illness centred, rather than patient centred care[132]. Although Western medicine has provided valuable advances in medical treatments and technologies which have improved the health of millions of

---

[129] Naomi Adelson, "The Embodiment of Inequity: Health Disparities in Aboriginal Canada," The Canadian Journal of Public Health 96, supplement 2. (April 2005): S46. http://www.cihr-irsc.gc.ca/e/documents/Volume_96-S21.pdf (accessed 6 April 2008).

[130] Ibid, S46.

[131] Ibid, S47.

[132] Dr. Gilles Pinette, "Should We Treat Aboriginal People Differently?" (lecture, University of Manitoba, 12 February 2004).

people in Canada and internationally, the 'top' down approach to policy and administration in the federal government hinders effective health care for Aboriginals because it does not respect holistic healing and the grass-roots decision making that is fundamental to the Aboriginal world-view. The Canadian Institute of Aboriginal People's Health identifies this as one of the main problems with Aboriginal health care and research. "...research has not always helped Aboriginal communities, because it failed to address urgent health concerns and because there was little or no Aboriginal ownership of research projects."[133] The exploration of cultural differences between Aboriginals and mainstream Canadian society can help us understand why current Canadian health policy and programming may be inappropriate for Aboriginals, but culture is only one of several important cross-cutting issues in the field of Aboriginal health. Structural organization of government may act as a barrier to improving Aboriginal health, health policy and health services and is examined below.

Structural Problems

The structural organization of the Canadian provincial and federal governments is important to the study of Aboriginal health because it influences the development of policy and the delivery of services. The federal and provincial shared jurisdiction over Aboriginal health and social services has resulted in complex intergovernmental relations surrounding Aboriginal health care and confusion as to which government is responsible for what services. This in itself makes it difficult to ensure that Aboriginal peoples are included in decision making, and their input seems to get lost in the planning of policies

[133] J. Reading and E. Nowegesic, "Improving the Health of Future Generations: The Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health", *American Journal of Public Health*, Vol.92 Issue 9, (September, 2002), 1396.

and programs. Nowegesic and Reading state, "The disjointed relationship with provinces is the single biggest problem with First Nations health. By exclusion from federal and provincial tables such as the Social Union Framework, First Nations will be harmed..."[134] [135]

Provinces provide health care to most Canadians, but the federal government has assumed most of the responsibility for Aboriginal health care. However, the federal government is adamant that under section 92(7) of the Constitution Act, health is a provincial responsibility, and that this responsibility should extend to First Nation populations[136]. The federal government maintains that they provide health care for First Nations as a matter of policy and out of a moral rather than a legal obligation. Many Aboriginal people dispute this federal claim and refer to the "Medicine Chest" clause in Treaty Number 6:

> In the event hereafter of the Indian...being overtaken by an pestilence, or by general famine the Queen...will grant to the Indian assistance...sufficient to relieve them from the calamity that shall have befallen them...A medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the discretion of such Agent.[137]

The meaning and parameters of the "medicine chest" clause have been the cause of much dispute. However, the Indian Act of 1876 acknowledges the responsibility of the federal government to provide medical services to Aboriginal people[138].

---

[134] Nowegesic and Reading, 1396.

[135] The Kelowna process was something of an exception in this regard because it sought to involve Aboriginal organizations from the outset. It represented an attempt to bring all the players together and seek agreement on a multi-year game plan on some of the most important issues facing Aboriginal communities and mainstream governments.

[136] Fox and Long, 245.

[137] Ibid., 244.

[138] Ibid.

Although the federal government has had primary responsibility for Aboriginal health, the restructuring of departments and shuffling of responsibilities has resulted in an extremely confusing situation for Aboriginal people. The transfer of the responsibility of Aboriginal health from the Department of Indian Affairs (DIA) to the Department of Health in 1945 further fragmented Aboriginal health services and made it difficult for Status Indians to know who had authority over their health care[139]. The DIA maintained control over lands, housing, education and welfare, and even sanitation and hygiene but were no longer directly responsible for health care. However, as we have seen in the discussion of non-medical determinants of health, these issues are critical to good health, and they now belonged to a branch of government that was not responsible or concerned with the health of Aboriginal peoples[140]. These jurisdictional disputes and shared responsibilities have resulted in confusion over who is in charge. This can cause delays in important decision-making, and changes in policy and services in the field of Aboriginal health.

It can be argued that the bureaucratic and paternalistic attitudes entrenched in federal government institutions also hinder the effectiveness of Aboriginal health care and policy. The Indian Act of 1876 reflects a paternalistic assimilationist policy and demonstrates the accepted notion (at the time) that Aboriginal populations were "problem people" and that government intervention was necessary to control them and solve the "Indian Problem"[141]. This colonialist attitude set the stage for the establishment of

---

[139] Fox and Long, 245.
[140] Ibid.
[141] Augie Fleras, "The Politics of Jurisdiction: Indigenizing Aboriginal-State Relations," in *Visions of the Heart: Canadian Aboriginal Issues*, ed. David Alan Long and Olive Patricia Dickason (Toronto: Harcourt Brace & Company Canada Ltd., 1996), 156.

bureaucratic structures such as the Department of Indian Affairs. Although the paternalistic attitude toward Aboriginal people is no longer accepted as politically correct, the existing bureaucratic structures are rooted in it. As a result, the structure of Aboriginal-state relations is inherently flawed. Many Aboriginal groups advocate "indigenizing" Aboriginal-state relations[142]. This would mean moving away from "bureaucratization" which is a type of interaction premised on the principles of efficiency and rational control, and toward an open-ended relationship characterized by increased participation and inclusion of Aboriginal perspectives at all levels of decision-making[143]. Many political leaders of Aboriginal organizations would go farther than this and advocate for nation-to-nation negotiation. It is important to note that a wide range of demands and proposals have been made to ensure health services which are sensitive to needs of Aboriginal peoples. This implies giving real consideration to accommodating Aboriginal values that differ from mainstream Eurocentric values. Current bureaucratic structures seem unable to accommodate these values.

In recent years, the federal government has attempted to address some of these structural problems in relation to Aboriginal health care. Aboriginal people, through their political and administrative organizations, maintain that they are not appropriately involved in the planning of health care policy and services[144]. The Health Transfer Initiative, released in 1988 is a policy designed to gradually shift control of resources and responsibilities for community health services and programs into the hands of Aboriginal

---

[142] Fleras, 149.
[143] Ibid.
[144] Assembly of First Nations, *Assembly of First Nations Presentation Notes to the Commission on the Future of Healthcare in Canada* http://www.afn.ca/programs/health%20Secreetariat/assembly_of_first_nations_presen.html (accessed April 4, 2004).

communities[145]. The transfer program involves three stages: pre-transfer planning; bridging, wherein representatives from the community work with regional staff from FNIHB to establish a Memorandum of Understanding based on the research done in preparing the community health program[146], and the final stage which includes the signing of a Health Services Transfer Agreement and the community managing its own health programs[147]. A community health program can vary in nature from organizing preventative health clinics to hiring the nurses for the nursing stations. The Health Services Transfer Initiative allows communities some limited consultative power in the development of a Community Health Program, but primarily gives them control to administer federally designed policies. First Nations are still accountable to Health Canada and limited by its policies. Many Aboriginal people see transfer of true control as the complete transfer of control over policy making. The federal government tends to regard transfer of control as transfer of administrative responsibility, as demonstrated by their actions in the health transfer initiative. This is where the fundamental problem rests because the federal government is reluctant to relinquish any real decision-making power or control, and for First Nations people, health is inextricably linked to self-determination:

> Self-determination for Aboriginal peoples is a prerequisite for healing and the development of wellness – wellness meaning of body, mind and spirit. Control of their cultural rights, land resources, education, justice system and health care delivery must come into the hands of Aboriginal people first.[148]

---

[145] Health Canada, *Ten Years of Health Transfer First Nation and Inuit Control* http://www.hc-sc.gc.ca/fnih-spni/pubs/agree-accord/10_years_ans_trans/index_e.html (accessed 5 April 2008).

[146] Ibid.

[147] Ibid.

[148] Dr. Chris Durocher, in Fox and Long, 259.

The structures of government hinder effective health policy and programming for several reasons. First, they are riddled with confusing intergovernmental jurisdictional issues. Second, bureaucratic structures are entrenched in paternalistic attitudes and characterized by a 'top down' model of decision-making that is in sharp contrast to the grass-roots, collective decision making process inherent to the traditional world-view of Aboriginal people. The efforts of the federal government to address these problems by transferring control to Aboriginal peoples have not been sufficient for numerous reasons. It can be argued that disagreement among Aboriginal groups and organizations over the form the transfer should take has impeded the shift of control. It can also be argued that the band councils and regional bodies lack "readiness" in terms of skills, knowledge and capacity to assume responsibility for complex policy making and service delivery involved in health. However, underlying all of these issues is the fundamental unwillingness on the part of the federal government to relinquish true decision-making power. This leads us to the final cross-cutting issue discussed in this chapter: sovereignty.

Sovereignty and Resources: Canadian Interests vs. Aboriginal Interests

Currently, Aboriginal issues including health are often subordinated to Canadian "national interests". Boldt explains that the "national interest" is a concept used by the Canadian government to assert political, economic and social control over Canada and to perpetuate the illusion that all Canadians share a common set of interests[149]. If government policies are designed to promote these interests then they will be perceived as legitimate[150]. However, there is no single accepted way of defining the 'national interest' or 'national good'. These assessments are made by the political and bureaucratic

[149] Boldt, 67.
[150] Ibid.

elite without representation of the opinions and perspective of the less powerful or socially disadvantaged Canadians. In his book, "Surviving as Indians", Boldt writes

> ...Canadian governments, of whatever party stripe, have consistently subordinated Indian interests to the Canadian 'national interest' in their development of policy. None has developed policies with primary or coequal reference to Indian interests, right, needs, or aspirations.[151]

The federal and provincial governments control virtually all of the country's resources, meaning the Aboriginal interests must compete for resources with 'national interests', or the interests of all other Canadians. When it comes to health, the national interest lays in the widely accepted wisdom of Western medicine, which focuses on treating the illness, not the person[152]. This results in a health care system that does not represent the attitudes and beliefs of many of the people it treats. If Aboriginal people were to have control over their own health care they would no longer have to compete with the prevailing national interest, but would be empowered to find solutions to the endemic health problems specific to their communities. The problem is that true transfer of control over health or any area implies control over resources. Forecasts for RCAP indicated that First Nation governments would remain heavily dependent on financial support from mainstream governments for many years to come. This likely means that complete freedom or total control over their health systems will be difficult to achieve, unless the Government of Canada were to transfer blocks of funds with no strings attached and no accountability requirement. This is highly unlikely, and it is this control over resources that can be perceived as a fundamental threat to Canadian sovereignty. In the essay "The Politics of Jurisdiction: Indigenizing Aboriginal-State Relations", Fleras writes,

---

[151] Boldt, 79.
[152] Dr. Gilles Pinette, *Should We Treat Aboriginal People Differently?*.

> In the final analysis, Aboriginal demands for self-determination are inseparable from concerns over "who controls what" with respect to wealth, power and status. Yet central authorities are reluctant to relinquish jurisdiction unless such concessions are consistent with 'national" or "sectarian" interests. They are even more hesitant to accept Aboriginality as a basis for redrawing powers for fear of destabilizing Canada's legitimacy as a sovereign state. In contrast, First Nations prefer to maximize jurisdiction and powers as a means of reclaiming control over their lives and life chances.[153]

The Canadian government's concern regarding sovereignty is one factor that may operate to limit the implementation of the sweeping policy changes recommended by the RCAP to effectively close the health gap. However, it may be that the government is reluctant to approve spending with complete indifference as to how money is spent and with no mechanism for holding Aboriginal governments accountable.

Conclusion

There are myriad factors that have contributed to the ineffectiveness of government policy in closing the health gap between Aboriginal Canadians and the general Canadian population. These include colonial history, education levels, lack of economic opportunity, institutionalized racism and jurisdictional confusion, not to mention the fundamental threat to Canadian sovereignty that is associated with the Aboriginal view of self-determination and self-government. It was the massive weight of these factors and the Canadian government's inability to deal with them that led to the RCAP. The RCAP recommended sweeping changes in its 1996 report, many aimed at creating solutions to some of the root causes of the health gap. By integrating the Bradford and Kingdon theoretical models on policy change it can be assumed that in order for the ideas of RCAP to have translated into policy, they needed economic, administrative and political viability. They also would have needed to arise at a time

[153] Fleras, 167.

when the problem stream, the health policy stream and the Aboriginal politics stream all converged to create a window for policy change. It is easy to see why stakeholders are often overwhelmed by difficulties in effecting positive change. In terms of political theory the theoretical insights of Bradford, Kingdon and Hall are all helpful in understanding the dynamics that underly these difficulties. It is important to emphasize that royal commissions do not have the luxury of a blank slate on which they can draw completely new policies. There is a legacy of past policies and their consequences, which must be considered. Also, commissioners have to consider the 'feasibility' of their proposals, which can be understood in policy solution terms, economic/financial terms, administrative terms, and social/political terms. In other words, do we have usable knowledge to solve the problem, do organizations have the capacity and willingness to implement, and is there interest in favour of the change which is stronger than the interest opposed, what is the state of public opinion, and can politicians mobilize support and legitimacy for proposed actions?

With this in mind, the thesis now turns to the consideration of the Royal Commission on Aboriginal Peoples, with a special focus on its recommendations regarding health and the role that royal commissions play in public policy and change.

Chapter Four: RCAP and the Response

This chapter explains the objectives of the RCAP and its significance in relation to Aboriginal health and health care. The chapter reviews the reason for the creation of this particular royal commission and it examines how the RCAP recommendations relate to the public policy theory behind royal commissions. It further analyzes the recommendations made by RCAP in the context of their political, administrative and economic viability as per Peter A. Hall's policy innovation viability scale. In the context of this analysis the chapter explores reactions to the RCAP.

The Creation of RCAP

The Royal Commission on Aboriginal Peoples was established in 1991 with a mandate to address many issues of importance to Aboriginal peoples in Canada. Events of the time such as the Oka Crisis and the Meech Lake Accord raised the profile of Aboriginal issues. In an attempt to gain Aboriginal support for the doomed Meech Lake Accord and its constitutional amendments, then Prime Minister Brian Mulroney promised to appoint a royal commission on Aboriginal peoples. This promise did not garner the support necessary to pass the accord, which died in June of 1990. It was defeated for several reasons; primarily because of the clause recognizing Quebec as a distinct society and the restrictions on the future use of the federal spending power in areas of provincial jurisdiction. However, the most famous event associated with the defeat of the Meech Lake Accord is Manitoba MLA Elijah Harper's refusal to grant unanimous consent to proceed with the resolution to adopt the Accord in the Manitoba Legislature. His refusal was based on the fact that Aboriginal Canadians wanted recognition in the Constitution,

but had been left out of the negotiation process for the Accord. These dramatic events served to further raise the profile of Aboriginal issues.

Less than one month after the famed defeat of the Meech Lake Accord, Mohawks protested the building of a golf course on sacred land in Oka, Quebec, resulting in a high profile, 78-day stand-off between the Mohawks and the Quebec police. Tensions mounted and at one point the Quebec police launched tear gas at the Mohawk barriers and tried to cross. Terrifying chaos and confusion ensued and shots were fired. Each side had a different version of events, and each claimed the other shot first. This skirmish resulted in the tragic death of 31-year-old police officer, husband and father Marcel Lemay. The Oka Crisis captured the attention of Canadians and propelled Aboriginal issues on to the international stage. The media frenzy focused a spotlight on the social problems that plagued Aboriginal communities[154]. The commissioners later wrote about the high emotions and upheaval that characterized the nature of the first RCAP hearings in 1991:

> It was a time of anger and upheaval. The country's leaders were arguing about the place of Aboriginal people in the constitution. First Nations were blockading roads and rail lines in Ontario and British Columbia. Innu families were encamped in protest of military installations in Labrador. A year earlier, armed conflict between Aboriginal and non-Aboriginal forces at Kanesatake (Oka) had tarnished Canada's reputation abroad – and in the minds of many citizens. [155]

The intense conflicts in Canada during the late 1980's and early 1990's increased public demand for government action. The need for peaceful solutions to these rising tensions and to create reasonable and lasting terms for coexistence with Aboriginal

---

[154] Kanesatake, *The Summer of 1990*, http://www.kanesatake.com/heritage/crisis/media.html (accessed 6 April 2008).

[155] RCAP Report, *Word from the Commissioners*, http://www.ainc-inac.gc.ca/ch/rcap/rpt/wrd_e.html (accessed 7 April 2008).

people was clear[156]. This is a prime example of Kingdon's model of policy change, discussed in the previous chapter. The problem stream, the politics stream and the public policy stream converged to bring about the RCAP. However, part of Kingdon's model involves the availability of ideas which command support and represent solutions to the perceived problems. In the case of the RCAP, it does not seem as though a grand vision of the future relationship between non-Aboriginal peoples and their governments and Aboriginal people and their governments existed at that time, or for that matter, even now. Rather, the RCAP was a process response because a feasible policy was not available. However, it was hoped by many government officials, activists and Aboriginal leaders that the RCAP report could be as significant and innovative as some earlier influential government reports. For example, the Laurendeau-Dunton report of the 1960s ultimately resulted in the creation of the Official Languages Act and the Macdonald Report of the 1980's led to free trade with the United States of America and Mexico in the form of NAFTA[157].

The official mandate given to the RCAP was to examine all issues relevant to any or all of the Aboriginal peoples of Canada, and more specifically to:

> ...investigate the evolution of the relationship among Aboriginal peoples (Indian, Inuit and Metis), the Canadian government, and Canadian society as a whole. It should propose specific solutions, rooted in domestic and international experience, to the problems which have plagued those relationships and which confront Aboriginal peoples today.[158]

---

[156] CBC News In Depth, *Native Rights Movement*, 21 November 2006, available from http://www.cbc.ca/news/background/Aboriginals/native-rights-movement.html (accessed 6 April 2008).

[157] James S. Frideres "RCAP: The route to self-government?", University of Calgary, *Canadian Journal of Native Studies*, 1996, p 250. http://www.brandonu.ca/Library/CJNS/16.2/frideres.pdf (accessed 6 April 2008).

[158] CBC News In Depth, *Native Rights Movement*.

The commission listed a number of reasons why this must be accomplished; to validate Canada's claims of being a fair and enlightened society and to improve the low life chances of Aboriginal people. The commission also pointed out that negotiation as it existed at the time was fundamentally unequal to the task of settling grievances. The major concern was that a continued failure to find solutions could lead to violence[159].

With this important mandate, the Royal Commission on Aboriginal People began its hearings. It had a budget of approximately $12 million dollars and its report was expected in 1992 [160]. The Commission consisted of seven well known experts including Paul Chartrand, Peter Meekison, Viola Robinson, Mary Sillett, and Bertha Wilson, and was chaired by René Dussault, and Georges Erasmus[161]. Alan Blakeney, former NDP Premier of Saskatchewan was also an initial member but he resigned in protest based on the direction that the report was heading. He disagreed with the path of institutional parallelism being recommended by RCAP, which he felt denied the continued interdependence of Aboriginal and non-Aboriginal societies and also to the relative lack of attention given to the situation of urban Aboriginals. He held that RCAP listened too much, and focused only on the needs of the Aboriginal peoples, turning a blind eye to the broader context and reality of the situation[162]. To many people outside of the Aboriginal community, the resignation of a thoughtful and fair-minded person like Blakeney was troubling.

---

[159] CBC News In Depth, *Native Rights Movement.*

[160] Ibid.

[161] RCAP Report *Introduction.*

[162] Olive Patricia Dickason, *Recognized at Last? -- Some Reflections on the Royal Commission on Aboriginal People,* The Stanely Knowles Lecture, 22 October 1998, Waterloo University http://economics.uwaterloo.ca/needhdata/dickason.html (accessed 7 April 2008).

The commissioners conducted 178 days of public hearings, travelling to 96 different communities across Canada[163]. Consultation was a key part of the commission's process and they conferred with a variety of experts and listened to hundreds of witnesses. They met with leaders from regional, provincial, territorial jurisdictions and Aboriginal communities. These leaders represented over 100 Aboriginal organizations, provincial premiers, federal and provincial ministers as well as a wide range of other Canadians. The commission wanted the process to be open and encouraged grassroots participation through advertising the public hearings. All Canadians were invited to share their opinions either in writing or by calling a toll-free telephone number where they could provide input into these issues in English, French, Cree, Ojibwa or Iniktitut[164]. Another goal of the commission was to keep Canadians informed about the process and the issues through publishing discussion documents that were based on the public hearings. The commission also tried to consider various perspectives in the report, and consulted with experts in areas including health and social issues, women's issues, urban issues and economic development[165].

The goal of these consultations was to identify the steps necessary to produce positive change in policy, service delivery and other factors affecting Aboriginal Canadians. After consultation with some of Canada's top scholars, various research projects were undertaken. Ultimately, four major research themes were chosen: governance, lands and economy, social and cultural matters, and the North. These themes were researched in consideration of cross-cutting issues such as history, the role of

---

[163] CBC News In Depth, *Native Rights Movement.*

[164] Frideres, 251.

[165] Canadian Encylcopedia, *Royal Commission on Aboriginal Peoples*, (Audrey Doerr) http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=A1ARTA0011169 (accessed 6 April 2008).

women and youth and the issues faced by Aboriginal people in urban areas[166]. The commission established a set of ethical guidelines in order to ensure that research was conducted in a culturally sensitive manner, and that the Aboriginal experience was accurately represented. By the time the research was complete, the commission had over 300 studies, thanks to the efforts of hundreds of researchers from both Canadian and foreign universities.

The commission studied the historical relations between the government and Aboriginal peoples, as well as the current social, political, economic and cultural situations of Aboriginal peoples in Canada. They used this research to determine the possibility of Aboriginal self-government, the legal status of Aboriginal treaties, and to develop strategies to improve the circumstances of Aboriginal people. They even conducted research in the United States and Greenland in order to learn from the situation of other indigenous peoples in the world. The ethical guidelines encouraged the commissioners to move beyond conventional ways of thinking about research and resulted in a unique approach[167].

The RCAP Report

The final report of the Royal Commission on Aboriginal Peoples was published in 1996, consisting of 5 volumes, 440 recommendations and over 4000 pages[168]. The commission's report, which originally had a budget of approximately $12 million dollars,

---

[166] Canadian Encylcopedia, *Royal Commission on Aboriginal Peoples.*

[167] Jill Wherrett, "The Research Agenda of the Royal Commission on Aboriginal Peoples", In *Canadian Public Administration,* Volume 38, No.2 (summer) p 281.

[168] Mary Hurley and Jill Wherrett, *Brief regarding the report of the RCAP,* (Oct 1999, government of Canada Parliamentary Research Branch PRB 99-24E), http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/EB/prb9924-e.htm#SOME%20MAJOR%20FINDINGS%20OF%20THE%20REPORT (accessed 6 April 2008).

ended up costing close to $60 million dollars[169]. This was Canada's costliest commission at the time.

The report is divided into five volumes. Volume 1, *Looking forward, Looking back*, describes the commission mandate and the relationship between Aboriginal people, the federal government and Canadian society from an historical perspective. In light of this historical analysis, the commission provides recommendations on necessary principles for a renewed relationship. Volume 2, *Restructuring the Relationship*, identifies four basic pillars of this new relationship: treaties, governance, lands and resources and economic development. Volume 3, *Gathering Strength,* explores social issues, providing an analysis of and recommendations on family, health and healing, housing, education, justice, spirituality and arts and heritage. Volume 4, *Perspectives and Realities,* focuses on the Aboriginal experience in Canada through the exploration of various Aboriginal perspectives. It explores the diversity of Aboriginal people in Canada, and features the perspectives of Aboriginal women, elders and youth. The volume includes sections on the Metis and both northern and urban Aboriginals. Finally, Volume 5, *Renewal: A Twenty Year Commitment,* summarizes the discoveries and recommendations of the commission, reiterating the need for a renewed relationship based on the rebalancing of political and economic power between Aboriginal nations and other Canadian governments. This volume lays out the commission's strategy and stresses the need for public awareness and understanding of the issues. It also highlights the importance and the challenge of constitutional amendment[170].

---

[169] CBC News In Depth, *Native Rights Movement.*
[170] RCAP Report, Vol 3.

The scope of the commission was broad, and its report demonstrates the kind of focused research and policy ideas that royal commissions are capable of generating. After an examination of the RCAP recommendations on health and healing this chapter will turn to an evaluation of the soundness of the RCAP policy ideas – politically, economically and administratively. But first, we will explore the section on health and healing, which alone, comprised over 300 pages and 25 very specific recommendations[171].

RCAP Health and Healing

The RCAP report section on health and healing begins by focusing on the health reality of Aboriginal people, the determinants of health and existing services and policies. This exploration of Aboriginal health, healthcare and health services, begins in pre-contact times and continues into the 1990s. It discusses the common health problems associated with Aboriginal people and examines the health system that they have to deal with, relying on the testimony of experts in the field, elders, and citizens. The analysis of the testimony, statistics and reports led the commission to the following disturbing conclusion:

> We are deeply troubled by the evidence of continuing physical, mental and emotional ill health and social breakdown among Aboriginal people. Trends in the data on health and social conditions lead us to a stark conclusion: despite the extension of medical and social services (in some form) to every Aboriginal community, and despite the large sums spent by Canadian governments to provide these services, Aboriginal people still suffer from unacceptable rates of illness and distress. The term crisis is not an exaggeration here. [172]

---

[171] To view RCAP recommendations regarding health in full, see the RCAP report, available from http://www.ainc-inac.gc.ca/ch/rcap/sg/sgmm_e.html.

[172] RCAP Report, Vol. 3, C. 3, S.1.1.

The commission explores social and emotional health as well as community health, and they conclude that the causes of ill health among Aboriginal people are different from the causes of ill health among non-Aboriginal populations. As such, it seems logical that the prevention, cure and care for Aboriginal people will also be different. The commission maintains that the main impediment to restoring good Aboriginal health is not the amount of money that is spent but how that money is spent.

RCAP recommends a new approach to Aboriginal healing that is based on four main principles: equity, holism, Aboriginal control and diversity[173]. This new approach promises to focus on healing communities, nations and individuals by going beyond the service-focused nature of the current system and allowing a new concentration on numerous factors that influence the overall health of an individual. Equity would ensure that Aboriginal people in Canada have access to health services equivalent to those available to other Canadians, but more specifically, that the health system would produce *health outcomes* that are equivalent to those of other Canadians[174]. The commission emphasizes the importance of *health outcomes* because the root causes and the consequences of poor Aboriginal health are often unique. Therefore, equal services do not ensure equal outcomes. One way of addressing these unique problems and culture-specific circumstances is to redirect health services to meet the holistic needs of patients. Holism may offer solutions to the underlying social, emotional, environmental or even spiritual problems that influence health[175].

The RCAP report states that to be truly effective, Aboriginal health and healing systems must focus on primary health care in the form of health education and health

---

[173] RCAP Report, Vol. 3, C. 3, S.1.1.
[174] RCAP Report, Vol. 3, C. 3, S.2.4.
[175] Ibid.

promotion. It is essential that poor environmental conditions in communities are addressed as well as the many social economic and political factors that negatively impact health[176]. Arguably, one of the most important recommendations regarding health was that all governments recognize that health and self-government are inextricably linked. The report explains, "...we found overwhelming evidence that control of health and social services by outsiders simply does not produce good results — in any community."[177] Although the government, through policies like the Health Transfer Act, has agreed on paper that Aboriginal control over health services will likely improve Aboriginal health status, true decision-making power still eludes most communities.

Finally, the report says that the health system and services must reflect diversity and should be designed to allow for cultural differences. It presents an integrated health strategy which was developed in consideration of the research and analysis of existing services, policies and determinants of health. The report states:

> We considered criteria of efficiency and effectiveness that should be applied to any public program and that are especially important in times of fiscal restraint. We considered the huge and complex network of health and social institutions now in place – we are not beginning with a blank slate. We also considered that the urgency of immediate action on pressing concerns should be consistent with efforts to achieve self-government and self-reliance, which will proceed in parallel with service reorganization. [178]

The Commission proceeds to propose a four part strategy for improving health for Aboriginal peoples in Canada.

---

[176] RCAP Report, Vol. 3, C. 3, S.2.4.
[177] Ibid.
[178] RCAP Report, Vol. 3, C. 3, S.3.31.

1. The restructuring of the existing health and social delivery system which would lead to the creation of system of health and healing centres and lodges under the complete control of Aboriginal people;
2. The formation of an Aboriginal human resources development strategy that would work with the new system;
3. The full support of mainstream service, training and professional systems; and
4. A comprehensive infrastructure program to address serious environmental health threats in Aboriginal communities (clean water, safe waste management, and adequate housing)[179].

The first element is the core of this health strategy. These proposed healing centers and lodges would be accessible in urban, rural and reserve settings to all Aboriginal people; First Nations, Metis and Inuit. The primary purpose of the healing centers would be to offer community-based care that provides front-line services and would transcend the existing disintegration of service delivery for interrelated needs[180]. A healing center would play many roles and ideally would eliminate the fragmentation and conflict currently plaguing Aboriginal health care. In addition to providing emergency, preventative and rehabilitative services, a health centre may serve as a gathering place for support groups and various other targeted programs; it may provide child and family services and mental health services; it may also serve as a centre for participatory research. Above all else, the healing centres would reflect each particular community's health priorities and cultural understanding of health[181].

---

[179] RCAP Report, Vol. 3, C. 3, S.3.3.
[180] RCAP Report, Vol. 3, C. 3, S. 3.2.
[181] Ibid.

The commission proposes that healing centres would both supplement and work in harmony with the healing lodges. These healing lodges would provide residential treatment for family and community healing. In the current system, many Aboriginals who seek treatment for addictions and substance abuse or seek shelter from domestic abuse must leave their communities. This forces the individual out of the community for their period of treatment and returns them to the same difficult family situations where problems are perpetuated[182]. In contrast, healing lodges that are operated under Aboriginal control would likely reflect the centrality of the family in Aboriginal culture, more effectively addressing and dealing with the underlying causes of these problems, not the symptoms.

The report goes on to describe the existing community health clinics and treatment centres, explaining that the Health Transfer initiative, started in 1986, was a step in the right direction. However, the report holds that even in "transferred communities" innovation and creativity in providing these services is severely restricted by imposed policy and funding constraints[183]. Although community health clinics existed in all provinces at the time of the report, they were operating at the margins of a bio-medical health care system. The healing centres and healing lodges proposed by the commission would operate under Aboriginal control to deliver holistic and integrated health and social services.

The second element of the commission's health strategy is based on the creation of a human resource strategy that would allow Aboriginal people to become more actively involved and responsible for their own health care delivery. Through acknowledging the

---

[182] RCAP Report, Vol. 3, C. 3, S. 3.2.
[183] Ibid.

value of traditional knowledge and through massive training efforts, Aboriginal people would be empowered to reinvent Aboriginal health and social services. The commission recommends that the federal, provincial and territorial governments, as well as Aboriginal governments and organizations, pool their resources to encourage Aboriginal participation, planning and awareness of human resources development and training in health and social service professions[184].

The third element of the health strategy involves the full support of existing service delivery and training organizations to help facilitate the creation of, and smooth transition to health and service delivery systems that are under Aboriginal control. The commission acknowledges the fact that existing systems and services must be taken into consideration and used or adjusted to provide appropriate and effective health and social services to Aboriginal people. A key goal for mainstream programs and program providers must be to encourage and support the initiatives under Aboriginal control. They must also improve the effectiveness and frequently culturally insensitive services that are currently provided to Aboriginal people[185].

The fourth and final element of the RCAP health strategy involves raising the housing and community infrastructure in Aboriginal communities to the same level as the rest of Canada. The inadequate housing, unsafe water supply and poor sanitation capacity in Aboriginal communities are a dangerous threat to Aboriginal health. By implementing all four elements discussed in this strategy, Aboriginal health will improve. In order to maintain an improved level of health it is necessary to change the living conditions of Aboriginal people. Although a large financial investment is required in order to address

---

[184] RCAP Report, Vol. 3, C. 3, S. 3.3.
[185] RCAP Report, Vol. 3, C. 3, S. 3.4.

these infrastructure problems, the investment will ultimately pay by improving Aboriginal health and well-being, thereby increasing Aboriginal economic activity[186].

Viability of RCAP Recommendations

It is clear that the RCAP report includes numerous innovative recommendations and ideas for policy change, both broad and specific. In order to place these recommendations within the broader context of the Canadian policy framework discussed in the previous chapter, it is necessary to explore the economic, political and administrative viability of the ideas. It is beyond the scope of this work to provide an in-depth analysis of each recommendation. Instead, this section will identify some of the key potential problem areas in relation to the viability of the RCAP recommendations with a particular focus on the RCAP health strategy.

The RCAP was a unique social initiative of great magnitude that proposed a fundamental re-structuring of the country's social and political institutions, all to take place within twenty years[187]. Throughout the report the commissioners emphasize the importance of the inherent right to self-government, and identify health and healing as a core area for the exercise of self-government. The RCAP called for the incorporation of First Nations as full partners in Canada's confederation and advocated the establishment of a third order of government, an Aboriginal parliament called the "House of First Peoples" [188]. However, some suggest that the report fails to fully address the conflicts and complexities associated with shared authority within the Canadian confederation[189]. The nation-to-nation approach advocated by the RCAP is rooted in the concepts of diversity

---

[186] RCAP Report, Vol. 3, C. 3, S. 3.5.
[187] RCAP Report, Vol. 1, C. 1, S. 2.
[188] Olive Patricia Dickason, *Recognized at Last?*.
[189] Ibid.

and cooperation, whereas federalism is rooted in common standards and a uniform countrywide civic status. Dickason writes:

> ...it neglected to fully consider the equally important shared rule that is implicit in a confederation. Again to repeat a point, if federalism is about diversity, it is also about common standards and a uniform countrywide civic status.[190]

Adding another level of government to Canada's existing numerous layers of government was seen by many as yet another burden on public funds. Some were concerned that this approach would serve to further separate Aboriginal peoples from the rest of Canadian society, instead of promoting a harmonious relationship[191]. The RCAP report contains very little information on important practical issues such as the process for accountability within this new system. The RCAP report advocates self-government, but self-government is no guarantee for good administration. The report has been criticised for concentrating only on the Aboriginal point of view, and not adequately addressing the implications of its recommendations for Canada as a whole[192]. This may decrease the political, economic and administrative viability of RCAP's recommendations.

For example, the first pillar of the health strategy was to establish a system of health centres and healing lodges under Aboriginal control. The report outlined a fairly detailed framework for establishing these centres, and proposals for how they would be governed and administrated. To fully implement this recommendation would have required a large increase in funding from governments, something that was not well received at a time (the late 1990's) when governments were implementing massive cut backs. From a political perspective, increasing funding for Aboriginal issues, while

---

[190] Olive Patricia Dickason, *Recognized at Last?*.
[191] Ibid.
[192] Ibid.

making cutbacks in other areas may not have met with great public support, thus diminishing the political will to implement the recommendations. From an administrative perspective, reorganizing the entire health care delivery system to fall under Aboriginal control raised important questions about accountability, not to mention capacity (qualified staff at all levels) within the Aboriginal community to take over these services.

The second pillar of the RCAP health strategy was to develop a comprehensive Aboriginal Health Human Resources Strategy. This was an important and necessary action that seems viable from a political perspective. Economically, it may have been tough to allocate scarce funding to developing this initiative in the late 90's, but certainly no more difficult that to find money for anything else during that period.

The third pillar of the RCAP health strategy was to secure and enlist the support of mainstream health care delivery institutions in transferring services to Aboriginal control, as well as changing existing service delivery to better accommodate Aboriginal needs. Transferring administrative control is not shifting real decision-making power into the hands of Aboriginal peoples. The kind of true decision-making power called for in the RCAP report requires self-government. It will depend on the negotiated terms of self-government, which inevitably raises issues over control of economic resources. The report suggests that the new or renegotiated treaties would allow for self-government as well as the restoration of a 'fair share' of lands and resources in order to make self-government economically viable. As previously mentioned, the complexity and contentions associated with self-government negatively effect viability from an economic, political and administrative perspective. Another difficulty here might be to

expect the existing service delivery system to support and facilitate a transfer that will lead to the termination of their own jobs.

The fourth pillar of the health strategy was to address poor living conditions and lack of adequate infrastructure in Aboriginal communities. Again, the amount money required to significantly improve these conditions in a short period of time reduced the economic viability of this recommendation.

There are many reasons that the RCAP recommendations may have not been viable. While the political will to improve the situation of Aboriginal people was certainly present in the 1990's in a general way (leading to the RCAP itself), the will to entirely restructure Canada's social and political institutions was not. At a time of fiscal restraint, investing massive amounts of funding into improving the situation of Aboriginal people was not economically viable. This is NOT to say that it was economically impossible, or that it did not make economic sense. Rather, there were competing demands for limited resources, and Aboriginal issues did not garner the support necessary to implement the sweeping changes recommended by the RCAP. It is important to keep in mind that there are no easy solutions to affecting positive change for Aboriginal people. What is clear is that up until that point in time, Canadian policy regarding Aboriginal people had been ineffective and at the root of many of the social and economic ills that Aboriginal people faced. A drastic change was needed and the RCAP proposed drastic solutions. There is no question that the RCAP report succeeded in conveying the Aboriginal position. Many feel that it failed to adequately situate these issues and proposed solutions within the broader context of Canada[193].

Reactions to the RCAP Report

[193] Olive Patricia Dickason, *Recognized at Last?*.

Canadian scholar James Frideres conducted a study of the extent and nature of RCAP coverage in the print media over a four year period (1991-1994). According to Frideres, the coverage of RCAP was fairly minimal consisting mostly of short articles buried in various sections of the papers[194]. Not one article about the Royal Commission on Aboriginal people ever made it to the front page of the major newspapers in Canada[195]. This minimal amount of media coverage for such a massive commission is surprising, and goes to demonstrate that in general, the media did not deem the commission to be very important or newsworthy. As a part of this study Frideres also analysed the content of the articles, finding that less than half of the articles (42%) portrayed the commission in a positive light, while one third (35%) were clearly negative, focusing on the rising costs of the commission and the commission's alleged 'inability' to consider the viewpoints of stakeholders that were not Aboriginal[196]. This criticism gained strength after Mr. Blakeney's withdrawal[197]. Rene Dussault, one of the commissioners said,

> I am disappointed, although not surprised, that the media has focused on the costs of our recommendations. It would have been irresponsible on our parts to suggest fundamental changes without discussing what it would cost to realize them--or what it would cost to do nothing. Thus, we have included what it would cost in both cases. But the media is more interested in the short-term costs than in the value of the recommendations.[198]

Frideres concludes that in general, the RCAP did not raise the Canadian consciousness about Aboriginal people or Aboriginal-non-Aboriginal relations. However, it captured the

---

[194] Frideres, 253.
[195] Ibid.
[196] Ibid, 255.
[197] Ibid, 256.
[198] Rene Dussault quoted in the McGill Reporter, *Royal Commission on Aboriginal Peoples: Will study bring sweeping change or prove costly exercise in futility?* (Volume 29 - Number 10 - Thursday, February 13, 1997) http://reporter-archive.mcgill.ca/Rep/r2910/Aboriginal.html (accessed 7 April 2008).

interest of Aboriginal people and groups with a well-researched and thoughtful document that proposed alternative and sometimes radical ideas to bring about positive change for Aboriginal people.

The initial reaction of Aboriginal people to the RCAP report was generally very positive. It was hailed by some as an inspiring road map to the future[199]. Others were not convinced that it was a miracle solution to addressing the situation of Aboriginal people in Canada. Ovide Mercredi, the Grand Chief of the Assembly of First Nations at the time called the report Ottawa's "last best chance"[200].

The public reaction to the RCAP report was mixed. The $2 billion dollar proposed increase in annual spending over 15 years, to jump-start economic growth and social improvements for Aboriginal people seemed like an outrageous sum to many Canadians. The need for this money was well reasoned from an Aboriginal perspective – by spending the money now, the government would reap economic benefits in the future through increased Aboriginal economic independence, improved health and social situations of Aboriginal peoples. Another RCAP recommendation gained the attention of French-language Canada; specifically, the creation of a third order of government that would advise the federal and provincial governments on matters relating to Aboriginal people. Implementing these initiatives, particularly such a drastic restructuring of Canada, promised to be a complex and challenging endeavour.

The government of Canada did not release an official response to the RCAP report until January 7, 1998. Their response took the form of a "Statement of Reconciliation" within a document entitled *Gathering Strength-Canada's Aboriginal*

---

[199] Olive Patricia Dickason, *Recognized at Last?*.
[200] Ibid.

Action Plan. This document was widely interpreted as an apology, although the term "apology" was never actually used. Some criticized the document for being very carefully worded and vague about the government plan for implementing RCAP recommendations. Government action on the RCAP recommendations is explored in greater depth in the next chapter.

Summary

The Royal Commission on Aboriginal People was an important initiative that came to being during a time of conflict and unrest between Aboriginal peoples and the governments in Canada. It marked an important change in the way that Canadians perceived Aboriginal people and issues. It seemed that there was finally widespread acknowledgement that the situation of Canadian Aboriginal people was unacceptable and that something significant needed to change. The RCAP was created to find answers where there were no easy answers. The mandate was ambitious, to say the least. It was supposed to address the injustices of the past and find a way to move forward towards a brighter future for Aboriginal peoples. One of the major priorities of the RCAP was to find ways to improve Aboriginal health. The RCAP health strategy, based on four key points offered innovative policy ideas. However, many of the RCAP report recommendations may have been economically unviable due to the climate of fiscal restraint at the time of its release. It is important to stress that this does not mean that the recommendations were impossible or ill-conceived. However they did not acquire the political and public support necessary to insure that the RCAP ideas would be translated into new policy and initiatives. This was due, in part to the required massive restructuring and creation of new administrative systems, the proposed fundamental restructuring to

Canada's system of governance, and the proposed increase in federal government spending. However, without the political will or political champions the RCAP recommendations had little chance of being fully and successfully implemented. *Gathering Strength*, Canada's response to the RCAP report did not seem to reflect real political will to embrace the RCAP recommendations in their entirety. It certainly seems that this lack of political will despite the massive investment in the RCAP and obvious need for change, may be indicative of the need for education and better understanding of Aboriginal issues not only among the Canadian public but among the Canadian politicians and elite. The next chapter will explore the extent to which the RCAP recommendations have been put into action in the years since the release of the report.

Chapter Five: Changes Since RCAP

Chapter Five outlines the major changes in Aboriginal healthcare policy, delivery and outcomes since the release of the RCAP report. It includes an exploration of landmark legislation, policy and reports affecting the Canadian healthcare system and Manitoba First Nations as well as announced changes, new and modified initiatives and perceived changes since RCAP. Federal, provincial and Aboriginal policy and initiatives are examined to determine what has changed in Aboriginal health status, health services and health policy in the last 12 years.

It is beyond the scope of this thesis to attempt to directly relate these changes to the RCAP recommendations. However, through this analysis it may be possible to identify a 'climate of ideas' for which the RCAP is one source. Royal commissions can contribute to the identification of new policy /program ideas and they can also serve as a kind of incubator to keep fledgling policy ideas alive as they struggle to gain life in policy systems where numerous ideas compete for adoption. The trouble with royal commissions is that governments are under no legal obligation to act on their recommendations and the members of royal commissions often do not stay around to lobby for their ideas after the reports are tabled. Examining the major changes in the field of Aboriginal health since the release of the RCAP report will shed light on the climate of ideas surrounding RCAP. This analysis will also assist in the interpretation of elite interviews regarding the perceived impact of RCAP on health policy, services and outcomes.

Changes in Health Policy Since RCAP

Since the release of the RCAP report in 1996 there has been some forward movement and change in the field of Aboriginal health policy. This change has involved regionalization, Gathering Strength: Canada's Aboriginal Action Plan, the Romanow Commission recommendations, the creation of the Aboriginal Health Blueprint and the Kelowna Accord. Two other important policy pieces created during this time are the Aboriginal Health Transition Fund (AHTF) and the Aboriginal Health Human Resources Initiative. They were both part of the five year $100 million dollars federal government commitment to improving Aboriginal health, announced at the Special Meeting of First Minister & Aboriginal leaders in September 2004[201]. Through the examination of these high level plans, reports, legislation and policies it becomes clear that although they reflect an increased willingness of all stakeholders to collaborate on efforts to address the unacceptable situation of Aboriginal Health in Canada, it also becomes clear that the fundamental federally-controlled, prescriptive nature of Aboriginal health policy has not noticeably changed since the release of the RCAP report.

The 1998 *Gathering Strength: Canada's Aboriginal Action Plan* was the federal government's response to RCAP. It set out a policy framework for future government action based on four objectives: renewing the partnership, strengthening Aboriginal governance, developing a new fiscal relationship, and supporting strong communities,

---

[201] Health Canada, *Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting*, News Release 2004 http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_leaders-dirigents_e.html (accessed 11 April 2008).

people and economics[202]. Although some positive progress emerged from *Gathering Strength*, such as the $350 million dollar healing fund designed to deal with the legacy of abuse from residential schools, it has been described by both Aboriginal organizations and international human rights organizations as an inadequate response to RCAP[203]. Criticism has focused on the fact that *Gathering Strength* did not adequately address or provide for self-government or First Nations access to the lands and resources needed to be economically successful – key recommendations made by RCAP. Former grand chief Matthew Coon Come stated,

> No number of apologies, policies, token programs or symbolic healing funds are going to remedy this fundamental socio-economic fact.... The government must act on the RCAP recommendations on the redistribution of natural resources. We need real partnerships, real joint ventures. I don't see a signal that there is any change in the treatment of Indigenous peoples in Canada. I see the status quo and our communities are social time bombs.[204]

Despite acknowledging the importance of the findings of the RCAP, *Gathering Strength* did not demonstrate a clear willingness on the part of the federal government to act on the most important recommendations of the commission, particularly transfer of economic resources and self-government.

In Manitoba, one of Canada's most ambitious self-government initiatives was signed in 1994, and continued for the next thirteen years (eleven of which followed the release of the RCAP report). The scope and objectives of this Manitoba Framework Agreement Initiative (MFAI) were totally open and the agreement fell outside of the

---

[202] Mary Hurley and Jill Wherrett, *The Report of the Royal Commission on Aboriginal People,* (Law and Government Division, October 1999) http://www.parl.gc.ca/information/library/PRBpubs/prb9924-e.htm (accessed 11 April 2008).

[203] Ibid.

[204] Paul Barnsley, *"Cree Chief Slams Gathering Strength"* , Windspeaker, (Ottawa, January 1999) http://ammsa.com/windspeaker/WINDNEWSJAN99.html#anchor199807 (accessed 11 April 2008).

constraints of the federal government's policy framework on self-government in place prior to 1994. This meant that the MFAI held the potential to fully achieve RCAP suggestions with regard to self-government for Manitoba First Nations. The extraordinary potential born of this agreement to negotiate did not materialize. The hope engendered by the breadth of objectives and the nominally co-operative approach of the MFAI was burdened by the reality of federal reluctance to provide funding adequate to the nature of the task, a lack of engagement by the federal bureaucracy on joint efforts and demands for rapid and visible progress despite the complexity of the issues and the need for truly informed consent from the peoples affected. The MFAI has been suspended by Manitoba First Nations because they no longer believe the federal government supports the process. The federal government has provided no rational articulation of why the process did not produce tangible results, but has expressed dissatisfaction with the amount of money consumed by the process. A recent article in the Winnipeg Free Press comments on the difficulties:

> It became clear that First Nation people wanted true change, but were afraid of what that change would mean for existing treaties, programs and funding. First Nation leaders understood the critical requirement of truly informed consent to legitimize any agreement and insisted that appropriate resources be put into liaising and consulting with individual communities. Ottawa would not provide funding for this activity and the First Nations sacrificed research for consultation, allocating research money to community work and laying off research staff.[205]

The article goes on to explain:

> In 1997 the AMC (Assembly of Manitoba Chiefs) developed a comprehensive strategy and work plan to guide the activities under the agreement. This plan required double the 1997 money allocations and involved negotiating with

---

[205] *Who Set the Fire?*, B4.

> Manitoba in parallel with Ottawa to resolve crucial jurisdictional issues.... Canada refused to fund the Work Plan insisting on a piecemeal approach. [206]

The same article provides comment that emphasizes the difficulty the federal government and First Nations have interpreting objectives in a common manner and working jointly towards those objectives. The following comments are from Dr. Don McCaskill, the independent reviewer who conducted an evaluation of the MFAI in 1999:

> "Respondents consistently returned to two central themes which challenge the MFAI: firstly attempting to overcome 150 years of negative history in First Nations communities to move toward self government, and secondly, trying to forge an effective joint relationship between the parties based on mutual trust and respect. Until these issues are satisfactorily addressed it will be difficult for the MFAI to fulfill its potential."
>
> "The review has characterized the relationship between the parties as –Two Dichotomies- in that an effective relationship has not developed and lines of communication are at times strained. In addition no common vision or shared sense of direction is currently in place."[207]

The lack of progress experienced in relation to the MFAI has at various times been attributed to the impacts of the past 150 years of colonialism on First Nations communities, a profound lack of trust between the First Nations and government, an extremely complex set of issues, the largest of which involves jurisdictional disputes and control over resources and policy setting, and the reluctance of existing bureaucracies to yield to new approaches. All these obstacles appear to be part of the problem set surrounding First Nation – government relations of all types. The struggle to overcome these obstacles is aggravated by a lack of understanding by the general Canadian public of the realities of life in First Nation communities and the reality of the way governments

---

[206] *Who Set the Fire?*, B4.

[207] McCaskill, Don, -Manitoba Framework Initiative Review Final Report-, 1999 http://www.aina.gc/pr/pub/ae/re/98-04/98-04_1_ehtml (accessed 8 April 2008).

conduct relationships with First Nations on behalf of Canadian society in general. To the extent that the obstacles referred to above are endemic to government-First Nation relationships in Canada, it may be expected that they will likely play a significant role in the Aboriginal Health sector as well.

Another major Aboriginal health policy document since the release of the RCAP report was the final report of the *Commission on the Future of Health Care in Canada*, better known as the *Romanow Commission,* released in November 2002. The mandate of the commission was to review Canada's health care system and make recommendations to enhance the system's quality and sustainability. The report, *Building on Values: The Future of Health Care in Canada* recommended extensive changes. First, it suggested that Aboriginal health funding be pooled to create a consolidated budget for Aboriginal peoples. According to the report, this budget should be used to fund Aboriginal health partnerships that would be responsible for developing policy, providing services and improving Aboriginal health[208]. The Romanow Commission also recommended that Aboriginals and Canadians living in remote areas be afforded access to the same level of healthcare as is provided to the urban population.

The reaction to the Romanow Commission was mixed. Many Aboriginal leaders welcomed the report and its recommendations while some criticized it for being assimilationist. One of the disappointments for Aboriginal groups was that there was no recommended funding increase to address the health conditions of Aboriginal peoples. Another concern was that although the Romanow report recommended the pooling of resources, there was no clear plan as to who would be responsible for providing what

---

[208] Canada. *Building on Values: The Future of Healthcare in Canada – Final Report.* Roy Romanow. (Romanow Report), (Ottawa: Minister of Supply and Services Canada), 2004, 52-59.

funding, and for how this funding would be allocated[209]. There was some concern that the responsibility for Aboriginal health was being 'handed-off' to the provinces. One Aboriginal columnist wrote:

> (Mr. Romanow's) answer has been to focus on partnerships between federal, provincial and First Nations agencies and the gradual devolving of Aboriginal health care to the provinces. This...will meet with resistance from Aboriginal peoples, who see health care as a treaty right and a federal responsibility. The approach of shifting funding to a new super-agency and the use of culturally sensitive approaches and programs that meet specific Aboriginal needs all have merit. But relegating us to junior partners and transferring responsibility to the provinces is a non-starter with the First Nations leadership.[210]

The recommendations of the Romanow Commission resulted in the creation of the Intergovernmental Committee on First Nations Health (ICFNH - formerly known as the Manitoba Romanow Joint Working Group) which meets monthly to develop innovative solutions and strategic projects to achieve better health outcomes for Manitoba First Nations people. At the federal level the committee has representatives from INAC, Health Canada and FNIHB. Representatives from the province come from Manitoba Aboriginal and Northern Affairs and Manitoba Health. The Aboriginal side is represented by people from AMC, MKO and SCO. Getting all stakeholders working together at the same table is certainly an achievement and a step towards better coordinated service delivery and care, but making significant change to policy – i.e. the way that we approach Aboriginal health care issues is slow and difficult. Jurisdictions still do not pool their

---

[209] Canada. *Early Responses to Romanow: Whose Views of the Future of Healthcare*? (PRB-02-26E, 3 December 2002) http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/EB-e/prb0226-e.pdf (accessed 13 April, 2008).

[210] Doug Cuthland, *Winnipeg Free Press*, A13, 5 December 2002. http://www.maeci-dfait.gc.ca/Aboriginalplanet/mission/mcps02november29-december05-en.asp?prn=1 (accessed 13 April, 2008).

funds as Romanow recommended. Although partnerships have been made, progress is slow largely due to persistent jurisdictional disputes.

In 2003 and 2004, the federal, provincial and territorial governments signed the "Accord on Health Renewal" with the purpose of improving quality, accessibility and sustainability of the public health care system[211]. As a part of the accord the government of Canada committed to a $17.3 billion dollars increase in health care funding over three years, which will rise to $34.8 billion dollars over five years[212]. In September 2004, a second agreement, the "10-year Plan to Strengthen Health Care" was signed. This ten year plan was created to ensure that the Canada Health Act was upheld and that all Canadians, regardless of social or economic status, had access to healthcare. Through this plan, the federal government would infuse an extra $41.3 billion dollars in health care over ten years. In order to secure funding stability the federal government agreed to legislate cash transfers until 2013-2014[213].

Major trends in renewal, some of which began in the 1990's, have continued, including the decentralization of health administration through the creation of regional health authorities. In 1997, the Manitoba Regionalization Act created non-profit corporations called Regional Health Authorities (RHAs), responsible for the delivery of health services in all 11 regions of the province[214]. These RHAs are also responsible for providing services to First Nations members off reserve. The federal government provides money to the provinces to compensate for this expense. However, jurisdictional

---

[211] Pan American Health Organization, *Major Trends in Health Legislation in Canada 2001-2005,* (November 2006) http://www.ops-oms.org/english/DPM/SHD/HP/health-legislat-trends-CAN05.pdf (accessed 13 April, 2008) 13.

[212] Health Canada, *First Ministers Accord 2003: Factsheet* http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/fs-if_1_e.html (accessed 13 April 2008).

[213] Pan American Health Organization, *Major Trends in Health Legislation*, 13.

[214] Manitoba Government, *Regional Health Authorities* http://www.gov.mb.ca/health/rha/index.html (accessed 13 April, 2008).

disputes over federal and provincial roles and responsibilities in Aboriginal Health are ongoing. A 2008 report of the Manitoba Regional Health Authority External Review Committee states:

> The fact that the Aboriginal population in Manitoba continues to have a much poorer health status than that of the non-Aboriginal population underscores the need for provincial, federal, RHA, and First Nations officials to resolve jurisdictional issues that stand in the way of the provision of health services.[215]

Renewal has also included the transfer of responsibility of many functions and duties previously performed by doctors or nurses, to other medical personnel. Recently, renewal has focused on attempts to manage wait lists, primary care delivery reform and electronic health records[216]. As a part of Health System renewal, the government of Canada has increased funding to address the health of Aboriginal people. This includes a commitment to improve integration of services by working with other governments and Aboriginal leaders to 'close the gap' in health status.

The Aboriginal Health Transition Fund (AHTF) and the Aboriginal Health Human Resources Initiative (AHHRI) were both part of the five year federal government commitment to improving Aboriginal health, announced at the Special Meeting of First Minister & Aboriginal Leaders in September 2004[217]. The goal of the AHTF was to improve the integration of federally-funded health services within First Nations and Inuit communities with provincial/territorial health services, improve access to health services, create health programs and services that are sensitive to the needs of Aboriginal people

---

[215] Manitoba. *Report of the Manitoba Regional Health Authority External Review Committee*, February 2008 http://www.gov.mb.ca/health/rha/docs/report0208.pdf (accessed 13 April, 2008).

[216] Pan American Health Organization, *Major Trends in Health Legislation,* 13.

[217] First Nations and Inuit Health Program Compendium, *Aboriginal Health Transition Fund (AHTF) and Aboriginal Health Human Resources Initiative (AHHRI)* http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/2007_compendium/5_infrastructure_e.html (accessed 13 April 2008).

and to increase participation of Aboriginal people in the design, delivery and evaluation of health programs and services[218]. This fund has been divided into three envelopes; Adaptation ($80m), Pan-Canadian ($40m) and Integration ($80m). There have been major delays in the rolling out of this initiative and there is an extensive approval process required to access these funds. Although this fund may improve coordination and collaboration between jurisdictions it has yet to make a significant difference in increasing Aboriginal control over Aboriginal health.

The Aboriginal Health Human Resources Initiative (AHHRI) aims to lay the foundation for long term systemic change in the supply and demand for First Nations, Inuit and Metis health related human resources through supporting changes in the educational system and professional environment to encourage Aboriginal participation[219]. Although the principles behinds AHHRI are admirable, to date the project has been slow moving. Much of the funding for AHHRI has remained within FNIHB and the programs have been slow to be implemented.

A major step toward improving Aboriginal health was the 2004/05, National Aboriginal Health Blueprint process, mandated by the Federal-Provincial Accord (2003). This process included nation-wide meetings, roundtables, summits and consultations on the topic of Aboriginal health. It resulted in the *Blueprint on Aboriginal Health: A 10-Year Transformative Plan,* that was considered by First Ministers and national Aboriginal leaders at their meeting in Kelowna, B.C., November 24-25, 2005. The Blueprint provided a framework for action and investment in closing the gap in health outcomes between First Nations, Inuit and Métis and other Canadians. The First Minister and

---

[218] First Nations and Inuit Health Program Compendium, *Aboriginal Health Transition Fund.*
[219] Ibid.

Aboriginal leaders entered into a non-binding agreement to move forward on these issues, often referred to as the Kelowna Accord [220]. It included a total federal investment of over $5 billion dollars over five years, of which $1.3 billion dollars was earmarked to stabilize and improve health services to Aboriginal peoples. The *Kelowna Accord* marked an unprecedented cooperation and collaboration by federal, provincial, territorial governments and First Nations, Inuit and Métis across Canada.

After the meeting in Kelowna, hopes were high for moving forward on improving Aboriginal health. Unfortunately, while the government initially agreed to the ideas driving the accord, there have been no tangible results. This illustrates the power of the Prime Minister to set the agenda unilaterally. The Kingdon model presumes dispersed power in the US political system, whereas the cabinet-parliamentary system, especially as it operates today, concentrates power in the hands of the Prime Minister. In fact, the Kelowna Accord has been largely ignored by the federal Conservative government. While the government has said that it agrees with the objectives and targets of the Accord, it has rejected the Kelowna commitments on the premise that the Accord does not provide sufficient detail. In March 2007, Parliament voted to resurrect the Kelowna Accord but the minority Conservative government chose to ignore the measure[221]. The Conservative government claims to be forging a new path with Aboriginal people in Canada and has often ridiculed the Kelowna accord for being a mere 'press release' and a validation of the status quo[222]. The 2007 and 2008 federal budgets contained little

---

[220] Pan American Health Organization, *Major Trends in Health Legislation,* 29.

[221] Canadian Press, *Tories to Ignore Parliament's Kelowna Accord Vote,* (22 March, 2007) http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070321/kelowna_vote_070321/kelowna_vote_070321?s_name=&no_ads= (accessed 13 April 2008).

[222] Anita Neville, *Tories Shamefully Playing Petty Partisan Games and Ignoring Serious Issues,* (8 February 2008) http://www.anitaneville.ca/2008_02_01_archive-news.html (accessed 13 April 2008).

mention of funding for First Nations issues, and tensions between First Nations and the federal government are escalating. In fact, Assembly of First Nations (AFN) National Chief Phil Fontaine said the government's 2008 budget ignored the plans put forward by First Nations in pre-budget submissions to the government. It seems that while the Conservative government is convinced their new approach to Aboriginal issues is far better than honouring the Kelowna Accord, they do not have the support of Aboriginal peoples. In fact, AFN leader Phil Fontaine said,

> I think we would all agree that the money ($5 billion dollars for the Kelowna Accord) went to a one per cent decrease in GST, because that also cost $5 billion," said Fontaine."Many say that there is enough money, that the problem is actually in structure," said Fontaine. "Of the $9 billion that supposedly goes to First Nations, less than $5 billion goes to First Nations governments--these initiatives speak well to people who believe that chiefs and councils are responsible for everything that is wrong with the communities. One can't argue in a reasonable way that chiefs and councils are responsible for this. What we are seeing is a terrible, disingenuous approach that says, 'Blame the victim.' The argument goes that First Nations are poor because of the reserve system, or because there are too many chiefs.[223]

While efforts have been made to improve the health status of Aboriginal people, the central recommendations of the RCAP report have not been implemented. In 2006, the Assembly of First Nations released a report card on the actions of the Federal government on the recommendations of RCAP. The AFN assessed 66 recommendations based on the level of federal government response. The government received 37 Fs, 11 Ds and two D minuses[224]. It scored only one A for establishing a National Aboriginal Day. According to this report card, funding for Aboriginal initiatives has not increased to the level

---

[223] University of Calgary Gauntlet, *First Nations Chief Calls for Government Action,* March 8, 2007 http://gauntlet.ucalgary.ca/story/11144 (accessed 13 April 2008).

[224]CBC News, *Ottawa gets Failing Grade on Response to Aboriginal Commission*, (21 November, 2006) http://www.cbc.ca/canada/story/2006/11/21/grade-government.html (accessed 14 April 2008) .

recommended by RCAP. In fact, there has been no sustained investment in meeting the basic needs of Aboriginal peoples or addressing the determinants of health and well being[225]. There has been inadequate growth in health funding, which has been capped at 3% per annum for 10 years. The report card estimated that Aboriginal communities will experience a gap of 9% (2006/07) and 14% (2007/08) between what they will receive in health funding and what is actually required in order to provide adequate health services to their people[226].

The Government of Canada has not officially recognized that the health of Aboriginal people is a foundational area for the practice of self-government by Aboriginal nations[227]. Health transfer policy has increased only administrative flexibility. Funding for transferred communities has been inadequate, which has resulted in rising deficits of community health budgets[228]. Another flaw with the health transfer policy is that certain Northern First Nations that have negotiated self-government agreements are ineligible to receive much needed targeted health programs. The report card points out that no framework has been developed to facilitate delivery of health and social services by Aboriginal organizations, under provincial or territorial jurisdiction. Federal, Provincial and Territorial (FPT) legislation, regulations and funding have not been sufficiently adapted to ensure FPT collaboration on integrated service delivery. Although there have been pilot research projects through the Health Transition Fund (Health Integration Initiative) there has been no adaptation of legislation or regulations, which

---

[225] CBC News, *Ottawa gets Failing Grade on Response to AboriginalCommission.*

[226] Assembly of First Nations, *Royal Commission on Aboriginal People at 10 years: A Report Card*, November 2006 http://www.afn.ca/cmslib/general/afn_rcap.pdf (accessed 14 April 2008) 3.

[227] Ibid, 14.

[228] Ibid.

would ensure the provision of permanent funding and pooling of resources[229]. This is probably because this kind of integration is in conflict with RHA structure and provincial jurisdiction. Another recommendation of the RCAP was for the formation of regional Aboriginal planning bodies to help improve service delivery and allocation of resources[230]. This recommendation has not been implemented or addressed. The Aboriginal Health Human Resources Initiative (AHHRI) announced in 2004 is certainly a step in the right direction, working toward the training of Aboriginal Health professionals. Still, much of the funding has stayed within FNIHB, with limited access to First Nation communities[231]. There has been some progress on the recommendation to recognize the value of traditional healing, primarily in the form of discussion papers or targeted areas like Aboriginal midwifery[232]. While certain limited progress has been made in the field of Aboriginal health policy in the last ten years, it is clear that the RCAP recommendations have not been implemented and significant change remains elusive.

Changes in Health Services Since RCAP:

Delivery of health services to First Nations in Manitoba has not changed much in the ten years since the release of the RCAP report. First Nation communities are located on a federal land base (reserves) and this federal land falls within the purview of provincial regional health authorities. What happens is that the federal government funds First Nations health services through the First Nations and Inuit Health Branch, and the provincial government. FNIHB funds public health nursing on reserves, community

---

[229] Assembly of First Nations, *RCAP at 10 years: A Report Card,* 14.
[230] Ibid.
[231] Ibid.
[232] Ibid.

health and prevention programs, and primary care services. Other federally provided programs include the Aboriginal Diabetes Initiative, the Aboriginal Head Start, Brighter Futures/Building Healthy Communities, the Canada Prenatal Nutrition Program, Non-Insured Health Benefits and the Fetal Alcohol Syndrome program[233].

The provincial government gives money to Regional Health Authorities for the delivery of some insured health services on reserve, including physician and hospital based services[234]. However, these services are not offered at the same level in all communities. Off reserve, First Nations people have access to all provincial health services. This confusing web of multiple players, jurisdictions, policies and administration puts Aboriginal Canadians at a disadvantage when trying to access health services.

One of the central issues in Aboriginal health in Manitoba has been jurisdictional disputes and ambiguity over the provision of health services to First Nations. This ambiguity has fostered the abdication and minimization of responsibility for Aboriginal health at the provincial and the federal level. These ambiguities and disputes have not markedly improved since the release of RCAP[235] and continue to be a major barrier to improving the health of First Nations peoples.

A prime example of how jurisdictional disputes can directly affect health service delivery is the now infamous case of Jordan Anderson. Jordan was born with a rare neuromuscular disorder in 1999 on the Norway House Cree Nation reserve in northern

---

[233]Intergovernmental Committee on First Nations Health, *First Nations Health and Wellness in Manitoba: Overview of gaps in service and issues associated with jurisdiction*, 2005 http://www.manitobachiefs.com/issue/health/First%20Nations%20health%20in%20Manitoba%20-%20final%20report%202005.pdf (accessed 14 April 2008) 14.

[234] Ibid, 15.

[235]Ibid, 18. This document contains a comprehensive list that details the areas of provincial and federal responsibility and the areas where there is jurisdictional ambiguity (most areas).

Manitoba[236]. He was quickly moved to a hospital in Winnipeg because his serious medical condition could not be managed within the community. Jordan's illness became progressively worse and he spent the first two years of his life in a hospital in Winnipeg. Finally, his physicians and his family decided that the best thing for Jordan would be a move to a specialized foster home near the Norway House reserve. At this point, the federal and Manitoba governments began to argue over who would pay for Jordan's care. Each claimed the other was responsible, and the debate lasted for over two years, while Jordan remained in hospital. The dispute was ended more than two years later, when Jordan died in a Winnipeg hospital, far from his family and community.

Arising from this tragedy is an idea called Jordan's Principle[237]. Under this principle, wherever a jurisdictional dispute arises over payment for health care of a First Nations child, the government (federal or provincial/territorial) that comes in contact with that child first, must pay for the services without delay. The idea is that the child's needs and health must be a priority, and that the jurisdictional dispute can be resolved later between bureaucrats, behind the scenes. In January 2008, a Private Members' Motion (unlike Private Members' Bills motions can involve the spending of public money because they simply exhort governments to do something) in support of Jordan's Principle was passed[238]. Although this is a step in the right direction, a private members' motion carries with it no obligation for government to spring into action. The last ten years has, however seen the formation of intergovernmental committees such as the

---

[236]Amir Attaran and Noni MacDonald, Canadian Medical Association Journal, *Jordan's Principle, government paralysis*, (Vol. 177(4): 321, 14 August 2007) http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1942093 (accessed 15 April, 2008).

[237] Ibid.

[238] The Free Library, *House Unanimous in Support of Jordan's Principle* http://www.thefreelibrary.com/House+unanimous+in+support+of+Jordan's+principle.-a0174281129 (accessed 15 April 2008).

ICFNH , which may demonstrate the increased willingness of stakeholders to discuss these issues and work together to find solutions.

Health Transfer

The continued implementation of the Health Transfer Policy (HTP) (1989) has resulted in some changes to the delivery of health services to First Nations. Health Transfer has meant that First Nation communities can take on the administration of a range of community-based and regional programs under a three to five year Contribution Agreement[239]. This allows communities to distribute funding based on local health priorities, and funding can be carried over from year to year. Integration is the other model of the Health Transfer Policy, which allows communities to take on a range of community-based services and allot funding based on their community work plan. This model is less independent than health transfer and communities must obtain consent from FNIHB to make decisions and changes. Also, the carry over of resources from year to year is not permitted under the integration model[240].

In 2005 the Centre for Aboriginal Health Research released "The Evaluation of the First Nations and Inuit Health Transfer Policy" report, which appraised the planning, administration and delivery of 'transferred'[241] health services by First Nation and Inuit communities. The report finds that in general, the Health Transfer Policy has reached some measure of success in achieving its stated objectives. First Nation and Inuit organizations have been given the opportunity to grow through the Health Transfer

---

[239] Health Canada, *Ten Years of Health Transfer.*

[240] Ibid.

[241] transferred services refers to health services that were transferred to local control on-reserve and in the communities.

Policy, and as a result service responsiveness has improved[242]. Mandatory health programs are being delivered and the accountability of Chief and Council in health matters has improved. The report finds that support for the program still exists within FNIHB and First Nations communities[243].

However, the report also identified numerous problem areas within health transfer:

- The current funding formula for transfer agreements has serious flaws which are resulting in inequities. The level of funding has failed to adjust with population growth and need levels[244].
- Transfer has further increased the confusion and complexity of service delivery and resulted in a 'patchwork' of services, programs and agreements. The administrative cost of maintaining this Byzantine method of service delivery is considerable. A 'system', not a patchwork is needed[245].
- The current accountability framework is inherently flawed. It has resulted in inefficiencies by demanding numerous reports that do not truly inform on the administrative and training needs of First Nation organizations, or on outcomes. First Nation administrators are forced to spend vast amounts of time writing these reports and not enough time on program planning and management[246].
- FNIHB standardization of programs and practices (an inherent government tendency) is contrary to the underlying principle of the Health Transfer Policy:

---

[242] Centre for Aboriginal Health Research, *Evaluation of First Nations and Inuit Health Transfer Policy* http://www.umanitoba.ca/centres/cahr/docs/health_transfer_exec_eng.pdf (accessed 15 April 2008) 24.

[243] Ibid.

[244] Ibid.

[245] Ibid.

[246] Ibid, 25.

> local control and flexibility to ensure care meets community needs. The report suggests that a more sensible alternative would be to focus on results-oriented benchmarks to inform on the overall performance of policy[247].

In summary, although Health Transfer has resulted in some positive changes in health service delivery in First Nation communities since RCAP, there is vast room for improvement. Communities need more money to adequately meet the health needs of their communities. Agreements need to be streamlined or simplified. The accountability framework needs to be overhauled to make it relevant, and flexibility and local control must be held as the key underlying principles of Health Transfer, and not lost to FNIHB's tendency to standardize.

Other Service Delivery Changes

Other changes in health service delivery over the last ten years include the increased focus on primary health care and disease prevention, an increased willingness to embrace holistic approaches to healing and the expansion of Manitoba Telehealth and health links in northern and remote communities.

Primary health care refers to health promotion, illness prevention and management of chronic health problems. Primary care extends beyond the boundaries of bio-medical health care model and addresses the broader non-medical determinants of health including housing, sanitation, education and numerous other factors[248]. Primary health care often includes the use of multi-disciplinary teams from different sectors to address the health of individuals, families and communities. Both the provincial and

---

[247] Centre for Aboriginal Health Research, *Evaluation of First Nations and Inuit Health Transfer Policy*, 25.

[248] Intergovernmental Committee on First Nations Health, *First Nations Health and Wellness in Manitoba: Overview of gaps in service and issues associated with jurisdiction*, 66.

federal government have made a commitment to Primary Health Care[249] however, there is ambiguity surrounding the federal and provincial government roles and responsibilities regarding the funding of Primary Health Care, healing and wellness centres in First Nations communities[250]. Currently, Primary Health Care programs in First Nations communities in Manitoba include recreation and fitness activities, lunch programs and health education in schools. Programs such as Aboriginal Head Start and the Canada Prenatal Nutrition Program have been well received. There is enormous potential in primary care initiatives, especially for First Nations because the primary health care model, with its focus on individuals, families and communities is consistent with traditional Aboriginal views about the interconnectedness of community, family, individuals and health[251]. The increasing emphasis on primary health care since the release of RCAP can be interpreted as a very positive change in service delivery.

The increasing use of holistic approaches to health and traditional healing can be seen as another positive change in health service delivery. For example, in December 2004, the Manitoba government announced the creation of the Aboriginal Midwifery Education Program[252]. This program offers a degree through the University College of the North and trains students in both traditional Aboriginal and western medicine. Other initiatives include workshops on traditional healing held by the Northern Aboriginal Population Health and Wellness Institute (NAPHWI) to determine how traditional healing practices and western medicine in the Burntwood Regional Health Authority can

---

[249] Health Canada, *2003 First Minister's Accord on Health Care Renewal* http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html (accessed 15 April 2008).

[250] Intergovernmental Committee on First Nations Health, *First Nations Health and Wellness in Manitoba: Overview of gaps in service and issues associated with jurisdiction*, 68.

[251] Ibid, 67.

[252] CBC News, Aboriginal Midwifery reclaims part of a lost culture, March 2006 http://www.cbc.ca/canada/manitoba/story/2006/03/01/win-Aboriginalmidwife060301.html (accessed 15 April, 2008).

compliment each other[253]. Traditional Healing clinics are held at the Health Sciences Centre in Winnipeg, which include consultations with healers and elders. While progress has been made in incorporating traditional healing into the health care of Aboriginal people, it is widely thought that more effort is required to familiarize the public with traditional medicine and create awareness for such practices to be accepted, integrated and respected in the health care system[254].

The expansion of MBTelehealth, a network that uses technology to connect residents of rural communities in Manitoba with health care services in urban areas, is surmounting the barrier of distance. Telehealth has been a positive service delivery change in recent years. It enables the health care professional and the patient to see, hear and talk to each other on a television screen, through a satellite or ground link[255]. MBTelehealth also supports health education delivery and administrative support to rural health authorities. There are currently 41 MBTelehealth sites in rural Manitoba and 14 telehealth sites in Winnipeg. In January, 2007 the MBTelehealth First Nations Expansion Project was completed. Through this initiative, 10 remote Manitoba First Nations communities have been linked into the MBTelehealth network. This has enabled the communities to use video conferencing to improve access to health care specialists and health related education. Communities may also use the video link to arrange meetings or visits with their family members and friends in care facilities far from home. Community leaders, Keewatin Tribal Council, First Nations Inuit Health Branch, Canada Health Infoway, and MBTelehealth, all collaborated to implement MBtelehealth in these

---

[253] Intergovernmental Committee on First Nations Health, *First Nations Health and Wellness in Manitoba: Overview of gaps in service and issues associated with jurisdiction*, 59.

[254] Ibid, 60.

[255] MB Telehealth. *Website.* http://www.mbtelehealth.ca/faq.php (accessed 15 April, 2008).

communities. The Assembly of Manitoba Chiefs is currently looking into options for future telehealth sites in other First Nations communities[256].

The overall increased focus on primary care as an essential component of the health care system is consistent with Aboriginal tradition beliefs and has resulted in the heightened profile of holistic and traditional healing. Access to care has been improving through MB Telehealth sites. It must be stressed that despite programs like MB Telehealth, transportation to and from remote communities for health care services continues to be a major problem, a high expense and a significant barrier to equitable access to services. The Health Transfer policy has resulted in increased capacity, accountability and control over administration of health services in First Nations communities as well as improved health outcomes and status. However, these transferred communities struggle with inadequate funding, unnecessarily complex administration and lack of flexibility. Jurisdictional ambiguity and disputes still play a central role in Aboriginal Health services in Manitoba despite the fact that the federal, provincial and Aboriginal governments seem increasingly willing to work together to find solutions to these problems. The next section provides an example and analysis of positive change in health service delivery in Manitoba since RCAP.

Island Lake Example

Unfortunately, there are very few positive examples of progressive health care and delivery of health services in First Nations communities in Manitoba since RCAP. One such example, cited in the ICFNH report on Jurisdictional Health Gaps, is the Island Lake Renal Centre/ Regional Primary Care Central Model. Poor health and poor health services have plagued the residents of the Island Lake Tribal Council (ILTC) region for

[256] MB Telehealth, *Website.*

many years. In March 2000 the CBC produced a documentary on the diabetes crisis in the area, which was the catalyst for tripartite negotiation between the ILTC chiefs, provincial and federal government officials. A Joint Health Governance Working Group was also created and pushed forward the development of an action plan. After extensive community consultations the ILTC Chiefs announced that a Primary Health Care Centre should be built to serve all First Nations in the district. This Centre would be located beside the new airport on an all weather road joining the two communities of St. Theresa Point and Wasagamack. The Centre would also offer dialysis services. The Renal Centre was built by Manitoba Health and is now operating. The long term plan of ILTC is to have the Four Arrows RHA act as a governing body over the Renal and Primary Health Care Centre (once the primary health care centre is built). However, this depends on a variety of factors, including the approval of the provincial and federal governments of the new conceptual plan and funding formula, the construction of an all weather road and the construction of the new airport. To date, the dialysis services have benefited some residents of ILTC region by allowing them to return from Winnipeg and receive treatment closer to home. However, inter-community transportation and housing for band members returning from Winnipeg is still insufficient[257].

The Intergovernmental Committee on First Nations Health used the example of the Island Lake Renal Centre/ Regional Primary Health Care Centre (despite the fact that it is still in early stages) as a model for the development of positive change in the field of Aboriginal Health in Manitoba[258]. Certain factors/events can be identified that have helped this particular project achieve some level of success. For example, the media

---

[257] Intergovernmental Committee on First Nations Health, *First Nations Health and Wellness in Manitoba: Overview of gaps in service and issues associated with jurisdiction*, 72.

[258] Ibid.

coverage of the serious First Nations health issue created a 'window' for policy change. Suddenly, there was the political, administrative and social will to work together to address the problem. In this example, not only did First Nations serve as a full partner at the negotiations table, but First Nation leaders shared a clear and common vision. The working group had a clear mandate to negotiate between all parties and find common ground. They followed a detailed work plan to sustain and track the advancement of the project. The ICFNH report claims that a key component of successful progress on Aboriginal health issues is that jurisdictional issues must be resolved between all parties, particularly in terms of funding roles between the provincial and federal governments[259].

Since the release of the RCAP report in 1996, health transfer has continued to shift administrative control and a small amount of decision-making power over health services to First Nation communities. There has been an increase in primary and preventative care, as well as a heightened awareness and acceptance of Aboriginal traditional holistic medicine. Access to care has been somewhat improved through initiatives like MBTelehealth, and all parties seem to have acknowledged the fact that in order to effect positive change, they must work together to address the health gap. However, Aboriginal Healthcare service delivery is still plagued with problems. There is a desperate need for increased integrated service delivery – easily accessible health care that addresses not only sickness, but focuses on the emotional, mental, spiritual and physical well being of the individual, the family and the community. Access to care continues to be a significant problem, especially on reserves. Unless both health policy and health service delivery address the underlying socio-economic problems of poverty,

---

[259] Intergovernmental Committee on First Nations Health, *First Nations Health and Wellness in Manitoba: Overview of gaps in service and issues associated with jurisdiction*, 72.

poor housing, low levels of education, poor nutrition, low self-esteem, isolation and unemployment, the health gap will remain a vast chasm that tears at the fabric of Canadian society.

Changes in Aboriginal Health Status Since RCAP

The poor health status of Aboriginal people in Canada and Manitoba was discussed in detail in Chapter Two of this thesis. The question remains, has there been any significant improvement in the health status of Aboriginal peoples since the release of the RCAP report in 1996? The answer is complicated. First of all, obtaining recent health statistics of Aboriginal populations is difficult. Many statistics focus solely on First Nations populations and some focus only on First Nations populations on-reserve. Another problem is that many Aboriginal people do not want to share information with the federal government. In general, the most recent available Aboriginal /FN health statistics are from the years 2000-2005, with most 2006/07 data still unavailable. The following section briefly examines some key areas related to the determinants of health and notes any obvious changes since the RCAP in the health status of Aboriginal peoples. Information presented in this section represents the most recent comparable data available to the researcher and comes from numerous sources.

Population

The Aboriginal population in Canada has increased by 45% since 1996[260]. During the same time, the non-Aboriginal population only grew by 9%. In Manitoba, the

[260]Statistics Canada, *Size and Growth of the Population by Aboriginal identity, Canada, 1996 and 2006*, Census 2006 http://www12.statcan.ca/english/census06/analysis/Aboriginal/surpass.cfm (accessed 17 April 2008).

Aboriginal population has grown from 128,910 people in 1996[261] to 175,395 people in 2006. Approximately one in six Canadian Aboriginal people live in Manitoba[262]. As the Aboriginal population of Manitoba increases, so do the demands on the health care system. It is therefore becoming increasingly important to improve the health status of Aboriginal people.

Health Indicators (life expectancy, infant mortality, PYLL)

There are many indicators of health, and it is important to reiterate that changes in health status cannot, given the parameters of this thesis, be linked with any kind of certainty to the recommendations of RCAP. They do, however, shed light on the continuing inequities between First Nations and other Canadians. For example, life expectancy at birth for First Nations people in Canada remains unacceptably low[263]. In fact, a provincial population-based look at health inequalities published in the *Canadian Journal of Public Health* in 2005, found that in Manitoba, First Nations people live approximately eight years less than other Manitobans[264] [265].

The infant mortality rate for First Nations in Canada continues to be higher than the Canadian rate. In 2000, the First Nation infant mortality rate was 6.4 deaths per 1000 live births while the Canadian infant mortality rate was 5.2 deaths per 1,000 live births

---

[261] Statistics Canada, *Aboriginal population by Province and Territory*, Census 1996 http://www40.statcan.ca/l01/cst01/demo40c.htm (accessed 18 April, 2008).

[262] Service Canada, *Aboriginal People in Manitoba*, 2006 http://www1.servicecanada.gc.ca/en/mb/Aboriginal-profile/Aboriginals.pdf (accessed 18 April, 2008) 33.

[263] In 1990, First Nations men were expected to live to be 67 years old. First Nations women were expected to live to the age of 74. This marked a 7.5 year gap between First Nations men and other Canadian men, and a 6.8 year gap between First Nations women and other Canadian women. The most recent statistics are from 2001, and the gap has closed slightly for men with a 6.7 year difference and a 4.7 year difference for women. This gap is still wide and unacceptable.

[264] PJ Martens, D. Sanderson, and L.S. Jehamani , (2005) *Mortality Comparisons of First Nations to all Other Manitobans : A provincial Population-based Look at Health Inequalities by Region and Gender*, Canadian Journal of Public Health, (Volume 96, 33-35).

[265] This suggests that First Nations populations in Manitoba have poorer health status that FN across Canada as a whole. Reasons for this may be the number of isolated reserves, and higher rates of poverty.

(in 2001). This marks a 22% difference. Although there has been a steady decline in infant mortality rates since 1980,[266] in Manitoba the infant mortality rate is much higher than the Canadian average at 6.6 deaths per 1,000 live births (2001). The infant mortality rate for Status Indians in Manitoba is three times higher than the non-Aboriginal rate[267].

Potential Years of Life Lost (PYLL) measures the years of life lost when a young person dies. The PYLL for First Nations people is higher for most causes of death and is particularly high in Manitoba – 2.5 times for males and 3 times higher for females[268]. The First Nations PYLL rate for injury (including motor vehicle accidents, suicide, drowning and fire) is almost 3.5 times that of the Canadian rate (2001)[269]. Intentional injuries such as suicide, violence and drug overdose are still high among First Nations populations[270].

Other poor health indicators are persistent. Aboriginal people are more likely to be disabled, to suffer from fetal alcohol syndrome, arthritis, mental illness, HIV/AIDS and chronic conditions like diabetes and heart disease.

Illness and Chronic Disease

One of the most disturbing changes since the release of the RCAP report in 1996 is the dramatic rise in the prevalence of circulatory, respiratory, and infectious diseases in First Nations and Aboriginal populations[271]. The prevalence of diabetes in First Nations people in 2001 was 4.2 times higher that it was among other Manitobans (18.9% versus 4.5%). This showed a significant increase from 1994 when the diabetes rate for First

---

[266] Treasury Board of Canada Secretariat, *Canada's Performance Report 2005,* Infant Mortality, http://www.tbs-sct.gc.ca/report/govrev/05/ann304_e.asp (accessed 17 April 2008) .

[267] Service Canada, *Aboriginal People in Manitoba*, 7.

[268] Martens, Sanderson and Jehami, 34.

[269] Treasury Board of Canada Secretariat, *Canada's Performance Report 2004* (IV: Aboriginal Peoples, figure 4.9) http://www.tbs-sct.gc.ca/report/govrev/04/cp-rc5_e.asp (accessed 18 April 2008).

[270] Health Canada, *Unintentional and Intentional Injury Profile for Aboriginal People in Canada*, http://www.hc-sc.gc.ca/fnih-spni/pubs/injury-bless/2001_trauma/5_dimension-aspect_e.html (accessed 18 April 2008).

[271] Service Canada, *Aboriginal People in Manitoba*, 6.

Nations was only three times higher[272]. Major risk factors for chronic diseases like diabetes, cancer and heart disease are often associated with lower socio-economic status. These can include poor health behaviors such as unhealthy dietary practices, lack of physical activity and substance abuse. Despite an effort made in recent years to raise awareness and improve the health behaviors of Aboriginal people, these habits and lifestyle choices continue to increase the risk of chronic disease in Aboriginal populations. Many of these poor health behaviors have been associated with poverty.

Socio-Economic Factors

The socio-economic factors that play a key role in health have not improved enough over the last ten years to greatly improve health status. Many people, especially in remote communities, still cannot afford healthy food. Some do not have access to refrigerators, some do not know healthy recipes. Often, cultural differences in perceptions of weight and eating play a role in determining health behaviours. Low levels of educational attainment have also been associated with poorer levels of health[273]. A comparison between high school completion rates of Aboriginals in Manitoba in 1996 versus rates in 2001 show that education attainment for Metis and Status Indians off reserve outside Winnipeg has improved. However there has been little or no improvement for Status Indians on-reserve or in Winnipeg[274].

Another socio-economic factor that has a direct impact on health is the availability and quality of decent housing. Aboriginal people are underprivileged in

---

[272] Service Canada, *Aboriginal People in Manitoba,* 33.

[273] Patricia Martens et. al. *The Health and Health Care use of Registered First Nations People Living in Manitoba: A Population-Based Study.*

[274] Service Canada, *Aboriginal People in Manitoba*, 46.

relation to all housing variables in comparison with the non-Aboriginal population[275]. In 1996, 41.5% of Status Indians (off reserve), 25.1% of Metis and 13.8% of non-Aboriginal people in Manitoba spent more that 30% of their income on housing. The statistics for 2001 were 32.1%, 19.5% and 12.7% respectively. This shows an improvement across all groups. However, the gap is still unacceptably large[276]. More Aboriginals are renters, and live in crowded situations. The quality and availability of housing for First Nations on reserve is even worse than it is in urban areas. In March 2004, there were 14,674 homes on reserves in Manitoba. Of these, 3,750 (25.5%) needed major repairs and 1,319 (9.2%) needed to be replaced[277]. It is common for more than twelve people to share a two bedroom home on reserves. These poor living conditions can contribute to increased family dysfunction, unsanitary conditions and health problems. Inadequate water and sewage infrastructure has lead to contaminated drinking water in some communities and this is an ongoing problem. It is quite possible that unless some major action is taken to improve living conditions on reserves, these housing, water and sanitation problems will get progressively worse as Aboriginal populations grow at a rapid rate.

The low income rate for both non-Aboriginal and Aboriginal people in Manitoba fell from 1996 to 2001[278]. Despite the fact that the median income for Status Indians across Manitoba increased from $8,029 in 1996 to $10,431 in 2001, it is still less than half of the non-Aboriginal median income at $21,684[279]. This lower income is closely tied to low levels of employment and education.

---

[275] Service Canada, *Aboriginal People in Manitoba*, 71.
[276] Ibid.
[277] Indian and Northern Affairs Canada (2004) *Housing and Infrastructure Inventory*, INAC, Manitoba Region.
[278] Service Canada, *Aboriginal People in Manitoba*, 63.
[279] Service Canada, *Aboriginal People in Manitoba,* 61.

Between 1996 and 2001 both Canada and Manitoba experienced strong economic growth and a rise in employment. In 1996, Manitoba's Aboriginal unemployment rate was 25.3% but by 2001 this rate had decreased to 19.1% [280]. Despite this reduction in the Aboriginal unemployment rate, the ratio of unemployed Aboriginal people to other unemployed Manitobans has changed very little. The Aboriginal unemployment rate was 325% that of the total population in 1996 and in 2001 had only decreased to 311%[281]. In Manitoba, Aboriginal unemployment rates are higher for all levels of education. This high unemployment rate combined with lack of labour-market participation and a growing young Aboriginal population, poses a major threat to the future of Manitoba's economy. Targeted programs such as the AHHRI and provincial government initiatives like MB4Youth may help to involve Aboriginal people in the workforce. However, addressing the unemployment problem on reserves is difficult. Reserve economies tend to be stagnant, offering very few employment opportunities and education attainment levels on reserves are particularly low. Without serious investment and control over traditional lands and resources as recommended by the RCAP report, it seems likely that Aboriginal peoples in Manitoba will continue to struggle economically, which has a direct impact on their health status.

Health Projections

While there has been some improvement towards closing the health gap in areas like life expectancy and infant mortality, the socio-economic factors that contribute to poor health status persist. The numbers for chronic diseases like diabetes are rapidly rising. The projections for future health problems and a widening health gap are

---

[280] Ibid, 55.
[281] Ibid, 9.

disturbing. It is estimated that the number of First Nations diabetes cases can be expected to increase by threefold within the next twenty years. As a result, diabetes expenditures, which took 2.4% of the provincial health budget in 1996, will take over 7% of the provincial health budget[282]. This means that in twenty years, more than twenty-five percent of First Nations adults in Manitoba will have Diabetes.

Summary

This chapter has outlined the major changes in Aboriginal healthcare policy, delivery and health status since the release of the RCAP report. This is not to say that these changes directly relate to the RCAP recommendations. It cannot be assumed that progress in any of these areas necessarily reflects structural, program or other changes. There may be other factors operating in the environment of the health policy field which caused the changes. However, the information presented in this chapter will help us interpret key informant interviews regarding the perceived impact of RCAP on health policy, services and outcomes.

While there has been some positive change in most of these areas, the major health recommendations of the RCAP report have not been implemented. The health gap between Aboriginal people and other Canadians is still vast and unacceptable. Even worse, the prevalence of chronic disease in Aboriginal populations is rising at an alarming rate.

The primary barrier to improved health outcomes and effective health policy and service delivery appears to be persistent jurisdictional disputes over control, responsibility and funding between the federal government and the province of Manitoba.

---

[282] Health Canada, *Diabetes Among Aboriginal People (First Nations, Inuit and Metis) in Canada: the Evidence* http://www.hc-sc.gc.ca/fnih-spni/pubs/diabete/2001_evidence_faits/sec_3_e.html (accessed 18 April 2008).

At the core of these disputes are several important issues. Firstly, the Aboriginal right to and desire for self-determination and secondly, the Aboriginal need for control over resources to realize this dream. Thirdly, is the provincial government reluctance to shoulder the financial burden for what they see as a federal responsibility. In the end, meaningful improvement in the health of Aboriginal peoples in Canada seems unlikely until the federal government sheds their reluctance to change their systemic bureaucratic structures and notions of control and works together with the province and Aboriginal groups to empower Aboriginal people and communities to heal themselves.

The next chapter explores these and other barriers to implementing the recommendations of the RCAP report, as identified by key informants. Elite interviews with key players in the field of Aboriginal health in Manitoba provide expert views and varied perspectives on the evolution of Aboriginal health, health policy and service delivery in Manitoba since 1996. These expert opinions will help contextualize and analyze the problem set involved in closing the health gap.

Chapter Six: The Interview Findings

Chapter Six reports on the findings of the interviews. It describes the academic rationale behind the research methodology and the interview process. The chapter explains the responses of the interviewees regarding the perceived impact of the RCAP and the perceived obstacles to improving Aboriginal health, health policy, and healthcare in Manitoba. It analyzes the perceptions of the interviewees, on the basis of critical issues identified in the literature review. This analysis allows for some general observations, but not definitive findings, regarding the perceived impact of the RCAP on Aboriginal health and healthcare in Manitoba, and the perceived obstacles to changing policy and programming aimed at improving the current situation.

Elite Interviews

The research method employed to obtain data for this part of the thesis is elite interviewing. Elite interviewing is a widely used method of collecting data through face-to-face interviews[283] with the experts or the 'elite' in a particular field. Elite interviewing is different from standardized interviewing in several ways. Standardized interviews are typically conducted by researcher with a clear question and problem, who looks for answers "within the bounds set by his presuppositions"[284]. An elite interview is fundamentally different in that the researcher must let the interviewee define the problem, the question and the situation. Elite interviewees are 'insiders' and there is inherent value in letting them guide the researcher through their expert opinions on other individuals, events, processes and institutions. This allows the researcher to learn from and draw upon

---

[283] Not all elite interviews are conducted face-to-face, but most (including most of those conducted for this thesis) are face-to-face.

[284] Lewis Anthony Dexter, *Elite and Specialized Interviewing*, Evanston: Northwestern University Press, 1970, 5.

the plethora of knowledge that elites typically possess. The central idea is to encourage *the interviewee* to determine what is relevant in relation to the subject. This is made possible by designing a flexible interview structure and creating questions that are open-ended. It is essential for the researcher to have a basic interview protocol and clear idea of the issues they wish to cover. However, it is important for the agenda to be flexible enough to allow for exploration of unexpected issues that may arise, as well as probing follow-up questions [285].

There are many benefits to conducting elite interviews[286]. For example, elite interviews are flexible and adaptable to different situations. They are not framed by the researcher's beliefs and prejudices. The open-ended questions and flexibility within the agenda permit the interviewee to define what is important – not the other way around. These interviews may provide a supplement to background research and other studies where information may be incomplete or non-existent, or transparency and enlightenment in relation to elite decision-making. Insider information may explain motives, intentions, actions and constraints related to policy making and implementation. Elite interviews may provide general expert and insider perspectives and information about people, events, processes, and organizations as well as well informed commentary on related matters, organizations, events or policies.[287]

There are also potential pitfalls of elite interviewing. While open-ended questioning is valuable it also raises concerns over validity and reliability issues. The interviewing skills of the researcher play an important role in the success or failure of an elite interview. The

---

[285] Alan Ware and Martín Sánchez-Jankowski , Elite and Specialized interviewing (introduction) http://www.essex.ac.uk/ecpr/publications/chapter/Dexter-Sample-Chapt.pdf (accessed 17 April 2008).

[286] *Notes on Elite Interviewing*, EPIC Workshop, Florence, May 2002. http://www.lse.ac.uk/collections/EPIC/events/Interviewing.pdf (accessed 17 April 2008).

[287] Ibid.

open-ended nature of elite interviews means that interviewers must know when to probe and how to formulate follow-up questions on the spot. Preparation and the use of recommended interview techniques can assist the interviewer. For example, the researcher may find it useful to write probe notes in his or her personal copy of the interview protocol to help them focus on the critical issues. It also helps to understand which questions may be answered in a short time and which require longer answers[288]. The interviewer must acknowledge the fact that it is not the obligation of the subject to be objective or to tell the truth. There are several ways to balance this potential for bias or untruth, such as employing numerous sources and conducting extensive research. It also may help to ask the subject to critique their own position. It is useful for the interviewer to prepare some standard 'bridges' to use when they wish to return to a subject area where information is still needed [289]. Finally, it can be difficult to take accurate notes while carrying on an open-ended 'conversational interview' with an elite. To solve this problem it is useful for the interviews to be recorded. This allows the researcher more freedom to listen carefully to the interviewee's responses, ask intelligent probing questions and to keep track of the agenda and the time.

This thesis focuses on the perceptions of people involved in the Aboriginal health care sector. The elite interviews are the most effective method of obtaining the *perceived* impact of the RCAP on Aboriginal health care and policy in Manitoba. As it is the perceptions of elites that are identified, not a universal truth, the validity concerns often associated with elite interviewing are significantly less. These perceived impacts of the RCAP are critically analyzed to determine if federal and provincial government

---

[288] *Notes on Elite Interviewing*, EPIC Workshop.
[289] Ibid.

interviewees and Aboriginal interviewees have different perceptions regarding the effects of RCAP and to what extent they share common perceptions. Through the interviews, the researcher also sought to identify the *perceived barriers* to significant improvement in the field of Aboriginal health in Manitoba. Analysis of these perceptions assist in delineating the problem set involved when considering policy options for the delivery of Aboriginal health care services. The document analysis and literature reviews were used to attempt to corroborate the perceptions recorded in the elite interviews. This represents a kind of triangulation approach to data gathering.

Interviews

In total, eight people were approached for interviews and were selected based on their knowledge of Aboriginal health and policy issues gathered through many years of working in the field. Two of the people approached were unable to participate in the interview process due to scheduling difficulties. In total six elite interviews were conducted in the research for this thesis. All the interviews were conducted on the understanding that the identity of the interviewees would remain confidential. Interviews were conducted with elites in the area of Aboriginal Health in Manitoba, and all interviewees had a long history of working with at least one of the major stakeholders involved - the federal government, provincial government or Aboriginal organizations. Interviews ran from 45 minutes to 90 minutes in length, depending on how much the interviewee had to say and their style of expression. The researcher conducted most of the interviews face-to-face, and two over the phone. The researcher used a basic outline of 13 interview questions during the interview, but in keeping with the principles of elite interviewing, let the interviewee identify the issues they felt were most relevant to the

topic.[290] All interviews were digitally recorded and then transcribed to facilitate analysis. It is important to note that no claim can be made to the representative nature of the respondents and their views.

Discussion of Results

Considering the non-linear nature of elite interviews, it would be inappropriate to discuss the results of the interviews question by question. Instead, the transcripts of the interviews have been analyzed to identify interviewee perceptions and comments in relation to the key issues identified in the literature review and in consideration of the conceptual/theoretical framework discussed in Chapter One (page 15). The conceptual framework indicated that the three fields of academic inquiry- public policy, health policy and Aboriginal politics-overlap, converge and interact in a complex network of governance. Analyzing how the multi-sectoral and multi-tiered governance process shapes the processes, outputs and outcomes in the field of Aboriginal health sector is inherently difficult. The results presented in this thesis are necessarily limited and tentative. However, the findings will help to increase our understanding of the impact of the RCAP on Aboriginal health, health policy and healthcare. They will also place the interview results in a theoretical and contextual framework within Canadian politics.

The discussion begins with a brief summary of interviewee perceptions of changes in health status, health services and health policy since the release of the RCAP report in 1996. This is followed by a review of interviewee perceptions of the political, administrative and economic viability of the RCAP recommendations. The interviewee perceptions of the viability of the RCAP recommendations are influenced greatly by

---

[290] A list of the interview questions used as a guide by the researcher during the interviews please see Appendix 1.

individual understanding and perceptions of the cross-cutting issues; structure, culture, sovereignty and resources. Interviewee ideas, comments and perceptions in relation to these cross-cutting issues are therefore explored next. Finally, the barriers to positive change in the field of Aboriginal health as identified by the interviewees, are discussed and analyzed in relation to the conceptual framework of public policy, health policy and Aboriginal politics.

Interviewee Perceptions of Changes Since RCAP

One of the key areas of focus in the interviews was the interviewees' perceptions of change in Aboriginal health status, health services and health policy since the release of the RCAP report in 1996. All of the interviewees indicated the view that there has been very little to no change in Aboriginal health status since the release of the RCAP report. Several speculated that Aboriginal health status may have actually become worse in the last twelve years, as evidenced by the rapid increase of chronic disease among Aboriginal people. A few interviewees remarked on the fact that any improvements that have occurred in Aboriginal health status over the last decade likely correspond to increases in economic prosperity and the rise of the Aboriginal middle class. One interviewee stated that this change has been gradual and is closely tied to improvements in educational attainment levels.

According to the interviewees, Health Services have also been slow to change and many of the problems that existed prior to RCAP are still the same. Of particular concern is the continuing inequity in access to health services that exists on-reserve and in remote communities. Some interviewees mentioned the new dialysis centres, many provincially funded, that are popping up on reserves in Manitoba as an improvement. These local

centres allow many Aboriginal people to receive the life-saving treatments they need without having to leave their community. One interviewee said,

> There's more dialysis units and renal health units popping up on Reserve, which you would hope that they would not be popping up anywhere, but even on Reserve and the province is paying for it. Which means there hasn't been necessarily a lot of progress towards keeping diabetes down or keeping renal health, or renal failure or dialysis down....it continues to go up....one good thing about that I guess in a sense, is that a lot of people always had to leave the community, leave their homes and come to Winnipeg or the larger centres to go on dialysis. With these opening up on Reserve some of those people get to go back home.[291]

However, it was noted by several interviewees that many communities still do not have dialysis services and the rapidly increasing need for dialysis treatment is indicative of poor health status, as well as health services and health policies that are failing to meet the needs of Aboriginal people. One interviewee recounted a story about dialysis patients from Cross Lake, highlighting the continuing struggle to access adequate health services in remote communities:

> Often there's no service in a community for dialysis. There were four patients in need of dialysis in the community of Cross Lake, which is connected to a highway but these people didn't want to leave their community. The federal/provincial policies state that there has to be at least five patients, dialysis patients before they'll put a machine in that community. Now to train a dialysis nurse it costs $50,000, but the machine itself is only $10,000. Anyway, you are saving a lot of money in the long run if you can buy the machine and provide service to five dialysis patients. Or even if you have two machines. Because every patient that goes through it, it takes from four to five hours. For dialysis, that's the stuff that cleans your blood out and it goes back. Very painful. I got these patients to come to Thompson but they got homesick. They had to come in three times a week to Thompson because the dialysis was needed. It was getting very hard for them. They couldn't comprehend that because it was taking them away from the community. And not only that but having to go on a bus for what, three hours. You get here. You go into a machine. You get back on a bus. It'd be another three hours. And I asked "Why don't we put a machine in Cross Lake even if there was only four patients? You (the federal government) are saving yourselves a lot of money." Just try and calculate in your mind how much the cost to bring three

[291] Interview with an expert in Aboriginal Health, February 21, 2008.

> patients three times a week, 52 weeks a year. That's a lot of money. You could have paid for a machine. You could have paid for training. There were four patients, but I lost three of them because they quit coming...they just couldn't cope with living off Reserve. I tried to find them a place in Thompson, but the federal policy states that they'll pay for the patient's accommodations for one month. After that one month the person's on their own to look after accommodations, taxi, the whole bit.[292]

Several interviewees mentioned that since the release of RCAP there has been an increase in focus on primary health and illness prevention initiatives. Unfortunately, these programs are not available in all Aboriginal communities. While there has been some increased degree of local control over the administration of health services through the health transfer programs, it was consistently mentioned by the interviewees that 'transferred' communities are under-funded. Several interviewees also noted that many of the health programs that are provided on reserves have limited or 'sun-setted' funding. Many of the best primary health programs are still not available in all communities. One interviewee said,

> There used to be just a few programs on Reserve, community based where they would hire community based workers, like community health representatives and Native alcohol and drug abuse workers, or NADAP workers, but now there's Maternal Child Health. There's FAS. There's Head Start. There's Youth suicide prevention. Prenatal.....so there's a lot more community based programs where there are workers hired by every community.....Unfortunately some of them are proposal based, or project proposal based, and so it's like a competition. Everybody has to send a proposal in, but only so many of them get funded. So for example, Head Start programs for the kids under six, there's thirty-two of the communities that have them, but there's thirty-two that don't. Some day it'd be good if they all had them...it comes down to the amount of money that gets given....by the Treasury Board. So that's the big change. There's a lot more community based programs, which is great, but unfortunately they're not all being provided at the community level. There is much more administrative control by First Nations than before. That's a plus. [293]

---

[292] Interview with an expert in Aboriginal Health, March 16, 2008.
[293] Interview with an expert in Aboriginal Health, February 19, 2008.

According to the interviewees, very little has changed in Aboriginal health policy, other than the increase in primary health programs. One interviewee felt that the provincial government focus on improving education for Aboriginal people was indirectly helping to improve Aboriginal health status. Other programs that interviewees felt reflected a change in policy were the Manitoba Healthy Child Initiative, Northern Healthy Food initiative and other prevention and early intervention programs. The creation of the Intergovernmental Committee on First Nations Health (ICFNH) was also mentioned by some interviewees as an example of gradual change in health policy, specifically because this group was designed to bring together federal, provincial and Aboriginal stakeholders. However, many interviewees agreed that even with this new group, progress on changing policy was almost non-existent. One interviewee specifically mentioned that the ICFNH has been working on changing policies on medical relocation and non-insured health benefits for many years, with very little success.

> We've been working on that since '04. Here it is '08, and really nothing in the non-insured health benefit policies has changed...so you have all the players at the table. It's very difficult to get policies changed. Some of the policies, particularly the non-insured health benefit policies, sort of transportation and dental and eye glasses, and et cetera, some of them are national policies, which are difficult to change. You know, that committee (the ICFNH) has been around for over five years and it's – it's really difficult to get the federal government and/or provincial government to agree on anything, or to get them to change their policies. It doesn't happen over night. Should it take five years or will it take five more? I don't know. I don't know. You know, but it's very difficult to get the policies changed.[294]

All interviewees stated that there has certainly not been the kind of change that was recommended in the RCAP report, which emphasized the importance of Aboriginal control and the creation of health centres and healing lodges. Throughout the interview

---

[294] Interview with an expert in Aboriginal Health, February 19, 2008.

process it became clear that all interviewees felt that Aboriginal health is still firmly entrenched in the structures of federal control over policy and standards. In fact, many interviewees felt that RCAP was likely not responsible for any changes in health status, services or policy. One interviewee went so far as to say that, " RCAP has had no significant impact on the day to day lives of Aboriginal people". Another interviewee felt that RCAP had a broad impact on changing the attitudes of Canadians on Aboriginal issues. The interviewee said,

> I think one of the major roles it (RCAP) played was in the attitudes of Canadians towards – you know, I mean, governments don't always lead. They tend to follow a lot. And the fact that society was educated through that process to recognize the plight of Aboriginal people, you know, it's become a point where governments have said, Well I guess we have to do something. Like everybody wants us to do something. And I've been working across Canada with different governments over those years and, you know, I saw a bit of a dip there after the referendum process. Especially with support for self-government. They said, We don't even want to talk about that any more, 'cause Canadians have spoken on that. But when it came to education and economic opportunities, providing for people to have better opportunities for employment and education, there was never any problem. I mean, people recognized that those were things that the general society supported very much.[295]

A few interviewees felt that RCAP may have had a positive impact in a very general way, particularly as an ambitious research document which could be referenced.

Interviewee Perceptions of Viability of RCAP Recommendations

Obtaining the interviewee perceptions on the viability of the RCAP recommendations was essential to understanding the changes discussed in the previous section. Most of the interviewees felt that the RCAP recommendations on health and healing, particularly the four pillars of the health strategy, were not viable. One interviewee said that the recommendations were viable in the sense that they were certainly needed and not impossible to achieve. This interviewee listed a few examples of successful healing

[295] Interview with an expert in Aboriginal Health, January 24, 2008.

centres under Aboriginal control. The interviewee also listed some examples of progress in the field of an Aboriginal Health Human Resources Initiative. However, the interviewee went on to explain that the funding for these initiatives is so inconsistent or non-existent that it acts as a barrier to implementing the RCAP recommendations. Many of the interviewee complaints about the viability of the RCAP recommendations focused on the lack of political will and resources to support the recommendations, thus making them unviable. One interviewee said,

> It's about the money. The Treasury Board hasn't provided us with any money to build a new centre (Aboriginal Health Centre). I'm not even sure the last time a new one was built.[296]

A few interviewees noted that the jurisdictional disputes played a role in decreasing the viability of the health recommendations because the stakeholders would very likely have been unable to resolve their differences and work together to implement the recommendations, particularly to create a network of health and healing lodges under Aboriginal control. One interviewee said that a system of healing centre and lodges that are under Aboriginal control "wouldn't work, because jurisdictions, both provincial and federal and inter-departmental would be fighting each other."

While most of the interviewees doubted the viability of the recommendations, several, especially those with Aboriginal background stressed that while the recommendations may have been unviable, they are nonetheless critical to improving the situation of Aboriginal health. Not one interviewee criticized the validity of the RCAP health strategy, rather they pointed out the unlikelihood that the recommendations would be implemented given the reality of the complex bureaucratic and jurisdictional maze

---

[296] Interview with an expert in Aboriginal Health, February 21, 2008.

associated with Aboriginal health. When asked about viability of the recommendations one interviewee said,

> They have to be viable. If we don't do exactly that (implement RCAP recommendations) the situation is going to get worse. I mean bottom line is your population health approach, looking at all the determinants that are influencing health. We know it's poverty. We know it's housing. We know it's education. We know it's economic development. And we know it's income status. But we don't choose to do anything about those root causes that are impacting our health. Unless we do that we are not going to get anywhere. I mean we can continue to operate in the manner that we do, and I don't know how we get away with it, accountability-wise. Because we're not doing a good job. [297]

The interview results indicate that lack of political will, lack of resources and jurisdictional disputes were at the heart of the viability concerns surrounding the recommendations of RCAP.

Interviewee Perceptions of Cross-Cutting Issues:

Four major cross-cutting issues were identified and discussed in the literature review: structure, culture, sovereignty and resources. These issues all have a strong influence over Aboriginal health policy, as demonstrated in the conceptual framework diagram in Chapter One, page 15. The interview results were analyzed to highlight interviewee perceptions of the relevance and role of these cross-cutting issues in the field of Aboriginal health.

Structural

All interviewees identified bureaucratic structures as a barrier to improving Aboriginal health. Interviewees perceived that too many layers of bureaucracy result in unnecessarily slow change. Several interviewees identified the bureaucratic tendency to adhere to the status quo, reluctance to embrace change, and the need for regional federal

[297] Interview with an expert in Aboriginal Health, March 16, 2008.

employees to seek approval from Ottawa before any decisions can be made, as structural problems that impede change. One interviewee said,

> Even the regional directors (of Health Canada) here have very little say in health policy, you know? When we have these ICFNH meetings, if we bring up something that has a policy to it, they just say, "We can't answer that. We have to check with Ottawa, you know?" So that part is very much not evolved.[298]

Interestingly, the interviewees with the federal government did not identify this as a problem. One interviewee noted that complex bureaucratic structures with competing or conflicting agendas are an issue. This is not only evident in the ongoing federal and provincial government jurisdictional disputes over responsibility for health care services and delivery, but can also be an issue between federal departments such as INAC and Health Canada, that have complex and some times overlapping division of responsibilities in relation to Aboriginal people. One interviewee said,

> There is a really fine line between Health Canada and INAC responsibilities...until such time as you're identified as medical, then you become Health Canada's responsibility[299]

This interviewee mentioned that this division in responsibility for services was a problem because there are so many determinants of health. Traditional Aboriginal views on health are holistic in nature, not divided by an imaginary departmental line. This same interviewee said that there are too many federal departments involved in Aboriginal issues and that there is a troubling lack of convergence. This increases confusion over who is responsible for what and this ambiguity was identified by all interviewees as a significant problem and barrier to positive health outcomes for Aboriginal people. Another aspect of the complex structural environment raised by one of the interviewees

---

[298] Interview with an expert in Aboriginal Health, March 16, 2008.
[299] Interview with an expert in Aboriginal Health, April 8, 2008.

was that the governments contract out many services to universities and other third parties, which can add another layer of bureaucracy and make things even more confusing. Several interviewees stated that lowering the centres of decision-making power and authority might go a long way to improving the effectiveness of Aboriginal health policy and services, One interviewee said,

> When you have to go through so many steps and so many people to get anything done, people get frustrated and tired, and upset because it takes so long to get anything approved, or it takes so long to find out it's not going to get approved. So there just has to be...a lowering of authority level.[300]

Several interviewees said that current health policies and funding formulas leave very little room for creativity and innovation. One interviewee said,

> One of the things one has to achieve in order to have effective change is to get all the different players on side and get them to buy into the concept of doing something creative and innovative in this area. And once you have achieved that bit – you know, it's not easy to do, but if you're able to get buy in from officials – and that's at every level from frontline to a Deputy Minister – you have a powerful force there for change and they can move things. And whether it's federal or provincial. Most public servants are looking for ways of making a difference. And they do that every day of their working career, you know. They want to do something good...they're not the barrier. The system they work in sometimes is the barrier. So it has to be changed. [301]

According to a few interviewees, these complex and rigid structures are not only a problem inherent to federal and provincial governments but are also evident within some Aboriginal organizations and bureaucracies.

Culture

All interviewees stated that culture plays a critical role in Aboriginal health. Interviewee perceptions of the role of culture included the importance of embracing and valuing Aboriginal traditional beliefs. During the interviews, culture was discussed in

---

[300] Interview with an expert in Aboriginal Health, February 19, 2008.
[301] Interview with an expert in Aboriginal Health, January 24, 2008.

reference to the culture particular to remote communities and on reserves, as well as Aboriginal cultural values and norms that effect lifestyle and behavioral habits, which in turn affect health. A few interviewees mentioned that the bureaucratic cultures of the federal and provincial governments promote adherence to the status quo, and this has a negative outcome for Aboriginal people who clearly need a new approach to health. One interviewee said that a "culture of dependence" exists within Aboriginal communities, and this culture plays a significant role in how Aboriginal people use and treat the resources that they are given. This kind of dependence and lack of self-sufficiency may lead to Aboriginal people exploiting or abusing the few resources they are given to survive. For example one interviewee said,

> It's kind of sad because I wish – I wish we could do something about it, just to be able to motivate each individual....the federal government has pretty well spoiled the people when they provide housing, education and everything else that you need. So why go to work? That's the biggest attitude they take towards that, but we got to train our people that there's more to the world than just being on reserve. They need to have the opportunity to take control over their own futures. If they can build their own homes I'm pretty sure nobody would turn around and abuse their own home.[302]

This interviewee statement highlights the sense of powerlessness that is so common on reserves. In the face of low economic opportunities and lack of self-sufficiency, there can be a general lack of pride in self and a tendency to abuse the few federal resources given to Aboriginal communities. Several interviewees said that culture plays a critical role in the relationship between Aboriginal Canada and mainstream Canada. Interestingly, all interviewees affiliated with Aboriginal organizations identified discrimination, racism and lack of understanding between mainstream Canada and Aboriginal Canada as a significant impediment to improving Aboriginal health. One interviewee said,

---

[302] Interview with an expert in Aboriginal Health, March 10, 2008.

> So that means we have to take a look at what we're doing, the system, and change it. And who better to ask than the people that are living there, that are accessing those systems. And you're going to see that there's racial involvement, institutional racism all across the board. And in this day and age you would kind of go, what? But it's there. And it's in our bureaucracy, and it's in our service delivery agencies. It exists. And I think until Canada says, No, the job that we've done around First Nations health has not been equitable. This is what we need to do, and get Canada to recognize that and see the changes. Then, yeah, I think then change can occur.[303]

This lack of cultural understanding leads to many misconceptions about Aboriginal people, often perpetuating negative stereotypes. This attitude in turn can have a direct effect on the care Aboriginal people receive. One interviewee said,

> They (Aboriginal people) are still not getting the kind of treatment that – I mean, when I say treatment, I mean all you ask for is respect. When you go to the person, medical care or whatever, all you want is to be treated with respect; right? And that's all people are asking for. And lots of times you're not getting – you don't get that....That's my honest opinion because it happened to me. You know, I've seen it. I've experienced it....In terms of cultural competence within the health care system itself, I find that is more of a challenge. Like I said, the WRHA is willing to do that. And they are in fact doing some cultural understanding sessions. But cultural competence to me doesn't necessarily mean just two days out of a year.[304]

Several interviewees mentioned that lack of cultural understanding may also play a role in how non-Aboriginal people prioritize issues of political importance – without a full understanding of the situation and history of Aboriginal people, other Canadians do not see Aboriginal issues as a priority. Therefore the politicians do not prioritize Aboriginal issues, resulting in a general lack of political will to implement serious change. This creates what one interviewee referred to as an "invisible holocaust" for Aboriginal people:

---

[303] Interview with an expert in Aboriginal Health, April 8, 2008.
[304] Interview with an expert in Aboriginal Health, March 16, 2008.

> Our people are living in what I call an invisible holocaust. Well, the reserves are pretty well like an invisible holocaust…You're damned if you do, damned if you don't, if you stay in or stay out… Got to be able to cope with life outside the Reserve. Off Reserve. But at the same time if they stay on the Reserve there's no – there's nothing pays, no career opportunities. There's really very little.[305]

Another interviewee said,

> This (improving Aboriginal health care) is going to have to be a decision that is made together, to say "let's do this". As socially responsible citizens of Canada. It's got to be. It's the only way. We've already been banging our heads against the same wall for 30 years if you know the 1971 response to the White paper. Back then First Nations said "This is not working for us. We want to be involved in our health care. We want to be involved in telling you what to do." It didn't happen. 30 years later and we're saying the same thing… nothing's changing. And we're saying WE are the answer. WE have the answers. Listen to us. But for some reason, and I'm going to say the "R" word, it's racist. It's the dominant society. Like if you look at how many jobs are within the federal government serving First Nations and Inuit needs. Think about it. It's sad. It's scary. And you have First Nations people saying, 'No, we know what to do. Give that responsibility back to us. It's ours. You've taken that.'[306]

It is important to note that no provincial, federal government or academic interviewees identified racism, or lack of public support as a problem, although they all identified lack of *political* support as a problem. In fact, one interviewee explicitly stated that public support and understanding was *not* a barrier to improving Aboriginal health. However, this statement was made in reference to educational programs, and not self-government initiatives. The interviewee stated:

> A study was done by a Canada West Foundation. They looked at education and employment and skill levels and all that stuff, and as part of that they did a survey of western Canadians and western Canadians were strongly supportive of making sure that Aboriginal people had the skills and education they needed to fully participate in society. It's just a given that if governments can do things in that area it will be applauded. It won't be criticized.[307]

---

[305] Interview with an expert in Aboriginal Health, March 10, 2008.
[306] Interview with an expert in Aboriginal Health, April 8, 2008.
[307] Interview with an expert in Aboriginal Health, January 24, 2008.

This may highlight a vast difference in perception and experience. Those with decision making power, within the federal and provincial governments did not highlight racism and discrimination and lack of public support for Aboriginal issues as a barrier, whereas all interviewees working with Aboriginal organizations sited racism, discrimination and lack of public support as being at the root of the most significant barriers to improving Aboriginal health. One interviewee said,

> Come on, what do people think? We have situations in our country that are third world and we are not responding. Do you know what that tells First Nations people? That they are worthless. They are nothing.[308]

Sovereignty

The cross-cutting issue of sovereignty, discussed in the literature review, has many layers. The fundamental conflict, identified by Menno Boldt, is that the Canadian 'national interests' are in conflict with the 'Aboriginal interests', particularly the control over resources. Aboriginal aspirations for self-government are inextricably bound to resources and issues of control. These issues may therefore be perceived to be in conflict with Canadian national interests and ultimately, a threat to Canadian sovereignty. Arguments over jurisdiction are evidence of this threat to sovereignty; First Nations self-government initiatives such as the Manitoba Framework agreement initiative of 1994 brought into focus the Aboriginal belief that Aboriginals in Canada did not give up jurisdiction, but simply have not had the resources to act on this jurisdiction. It is likely that this core belief was a central influencing factor behind the inability of the federal government and the Assembly of Manitoba Chiefs to develop an effective joint relationship under the agreement. Many Aboriginal people do not even consider

[308]Interview with an expert in Aboriginal Health, April 8, 2008.

themselves to be Canadians and feel that the Canadian government has no right to have control over Aboriginal policy in relation to health or any other area. This boils down to a fundamental difference in opinion over who is in charge of Aboriginal lives. It also comes down to this issue of who controls the resources.

None of the interviewees explicitly identified 'sovereignty' as an important issue or barrier in relation to Aboriginal health. However, all interviewees raised some issues that fall under the broader category of sovereignty. The interviewees consistently mentioned constitutional issues, jurisdictional issues, federal reluctance to hand over control to Aboriginal people. They also mentioned consistent under-funding for 'transferred' services. Several interviewees pointed out the federal government's refusal to adequately fund programs and services that would serve to build capacity among Aboriginal populations. The issue of sovereignty is inextricably linked with control over resources. One interviewee said,

> I believe in capacity building, but you know we taught that for many years, even through transfer, Gathering Strength, but we aren't really given the resources to do that. When you look at some of the health directors in the (Aboriginal) communities, a lot of them have post secondary education. A lot of them don't. I think there's more that do. But some communities don't even have dollars to support that position...we have to figure out some funding formulas that are going to meet the needs across the board – to finance thing appropriately, to include continuous capacity, lifelong learning...We need to get more creative with our resources - we are a rich country. Look at the population, how it's increasing in around First Nations. We're not using that pool of human resources to prepare us for the future...we're not stupid. We just haven't had the opportunities.[309]

Resources

The discussion around resources focuses on two key areas. The first is the lack of adequate resources allocated by the federal and provincial governments to improving the

[309] Interview with an expert in Aboriginal Health, April 8, 2008.

lives of Aboriginal people. The second focuses on the control over resources for economic development purposes. Some interviewees did observe that the increasing presence of a small Aboriginal middle class and higher levels of education seemed to contribute to some improvement in health outcomes for those Aboriginals.

> The evidence shows quite clearly that as people are able to gain some affluence, their overall health improves. And over that time, say from '96 until now...there's been I believe, a gradual increase in Aboriginal prosperity. There are more professional, there are more business people. There's more Aboriginal middle class and upper class citizens living in urban centres and even in communities. And I think you would find that them and their families enjoy a health status which would be comparable to other Canadians.[310]

Several interviewees felt very strongly that a socio-economic development strategy was a key component in improving the lives and health of Aboriginals in Manitoba. One interviewee said,

> If we could assist the communities to lift themselves up in terms of education levels and economic opportunities, then that would probably have even more of an impact on their overall health and, you know, putting in services for severe illness and critical disease that are there because of the poverty situations that the community finds themselves in.[311]

Another interviewee stated,

> If you are generating your own resources for your own self, and your community, and also for the future generations. Any excess amount, well, you could trade or sell, or use for the betterment of the community.[312]

This position is not very distant from the sovereignty and control issue because nearly every examination of development opportunities leads immediately to the issue of what resources are required to access the opportunity, who controls these resources and how Aboriginals can gain access to the required resources.

---

[310] Interview with an expert in Aboriginal Health, January 24, 2008.
[311] Interview with an expert in Aboriginal Health, January 24, 2008.
[312] Interview with an expert in Aboriginal Health, March 10, 2008.

Most interviewees agreed that Aboriginal health is severely under-funded by the federal government. One interviewee felt that in addition to under-funding, the important issue was how that money was spent. For example, federal policies tend to be formulaic and not flexible to suit the particular needs of a community. This results in gross misuse of funds in transportation costs – flying people out of the reserve to get treatment instead of bringing treatment to the communities. Other problems with formula funding were described by one interviewee,

> ...especially people that are living off Reserve really fall in the gap. Because funding is allocated based on formulas...The formula is based on band population. But that band population is say 1000. There's only 500 of them living on reserve. SO they're providing services to 500 people and not the 500 people living off reserve. There's a problem right there. It's sad but this happens. In the meantime the 500 people that are included in the formula are not getting anything for their dollar. However, education funding is based on on-Reserve population. So the First Nations community only gets funding for 500 people, but is expected to provide education for 1000 people and that puts them in a deficit situation right off the bat.[313]

Another interviewee pointed out that transferred health programs and self-government initiatives are so severely under-funded that it is nearly impossible for them to succeed. Two interviewees commented on some of the amazing work that has been accomplished in Aboriginal communities with such limited resources. While there have been some positive examples of success, interviewees indicated that these programs and 'experiments' with Aboriginal control can often be a negative experience for everyone involved. When transferred services are under-funded it ultimately sets the community up to fail. This can result in the community feeling that they are not able to run their own health services, and provides critics with examples of Aboriginal failures, feeding the widespread misconception that Aboriginal people lack the skills, capacity, and

[313] Interview with an expert in Aboriginal Health, March 10, 2008.

accountability, even the integrity to control their own resources and determine their own future. One interviewee explains:

> Self-determination or self-government has to be done in such a way that there's a right amount of supports to it. Otherwise it can appear to the people in the community that it's a failure and then the people who are running it are blamed rather than the system that supported it. And some of the research that's been done in BC – you maybe have seen that – where…they talk about the differences made in suicide rates depending on how much self-government there is. Well, I mean I think from a community perspective and someone living in the community, they have to see that as a real and effective self-governing and not a failure. If it's a failure it probably leads to the opposite effect. You know, of people saying, Well I mean , sure, we took this over, but it's not working. And look how incompetent we are. But, I mean, there are some – inspite of these shortcomings, people have risen to the challenge and are doing a reasonably good job, I think, of running these places and I think in a lot of cases doing a better job with the inadequate resources that they have available.[314]

Several interviewees identified the desire for accountability to work both ways; not just Aboriginal people being accountable to the federal government for the way programs are administered, but the federal government being accountable to Aboriginal people for the policy, services and money they are providing. All interviewees agreed that there has not been nearly enough funding allocated to improving infrastructure on reserves. In fact, there has been under-funding across the board when it comes to Aboriginal people. This federal government reluctance to dedicate adequate resources to improving lives of Aboriginal people was viewed by many interviewees as one of the central barriers to improving Aboriginal health.

> That's really the culprit, I think, is the (federal) , Treasury Board's accountant so they are looking at this purely from a financial perspective. And they think they're saving money. And I guess they are in a sense that they're off-loading it onto the provinces, but in the end, it's all one taxpayer. And the taxpayer ends up paying more because these matters are not being addressed in an effective way. And these disputes lead to, not the best system of addressing the issues. And as such,

---

[314] Interview with an expert in Aboriginal Health, January 24, 2008.

> they result in people having more serious consequences than they normally would need to have. And as a result, those are the high-end costs.[315]

Resources for Aboriginal people have been scarce since the late 1800's. Many of their valuable traditional lands and waterways that have potential to generate economic prosperity through the development of their natural resources have been taken from them and are under control of the provincial government, as a result of the Natural Resources Transfer Act of the 1939. Many Aboriginal groups have been relegated to remote and northern reserves where economic opportunity is scarce and economies tend to be stagnant. This has created a culture of dependence, where many Aboriginal people rely on government assistance as their only means of survival. Progress on land claims is slow, and the recommendations made by RCAP on this issue have not been fully implemented. Again, jurisdictional issues dominate as the province tends to consider Aboriginal populations to be the responsibility of the federal government, while the federal government tells Aboriginal people that their lands and resources are a provincial government jurisdiction. There was unanimous agreement among interviewees that economic and community development was essential in order to improve Aboriginal health. Some interviewees, both Aboriginal and non-Aboriginal, indicated that Aboriginal control over their own resources was a critical step towards economic development and improved health. All interviewees agreed that increased education and training for Aboriginal populations was a critical for economic prosperity to improve.

Barriers to Change

All the interviews were analyzed with particular attention to identifying the interviewees' perceptions of barriers to improving the health of Aboriginal peoples.

[315] Interview with an expert in Aboriginal Health, January 24, 2008.

These barriers are listed below in relation to where they fit within the conceptual framework; in the realm of public policy, health policy or Aboriginal policy/politics.

Public Policy

- Not all communities have the same access to federal primary health programs. Funding is not consistent, many good programs are not available to certain communities and can lead to competition between communities for funding.
- Persistent jurisdictional disputes between the federal and provincial governments. Very little room for compromise. Differing opinions and ambiguity over legal responsibility and funding. No one wants to pay.
- Provincial health programs are not offered on reserves.
- Federal government does not make Aboriginal issues a priority. There is a lack of funding and little commitment/willingness to take a new approach to address important issues.
- Aboriginal communities that try to take initiative and request funding to build new facilities etc are consistently told no by the federal government.
- Health transfer is not successful, largely because it is under funded and does not give real control to Aboriginal people.
- Even though all the players are at the table it is very difficult to change policy.
- Federal government doesn't acknowledge Aboriginal right to control their own health policy.
- There is still inadequate infrastructure (housing, roads, waste disposal, water and sewage) on reserves, which leads to persistent health problems.

- Accountability doesn't go both ways between the federal government and Aboriginal people.
- The1964 agreement has been a barrier.
- Jordan's principle has not been fully adopted by the federal government.
- The Conservative government dropped the Kelowna accord and there is a lack of willingness to engage on Aboriginal issues by federal government.
- Governments don't seem to realize the cost-benefits of investing in Aboriginal initiatives. Getting funding past the finance people in government is difficult. Federal government spending cap is at 2% per annum on reserves.
- Self-government initiatives have not been carried out with adequate financial support and have therefore been seen as failures.
- Federal health policy comes from Ottawa and has not evolved to include/reflect Aboriginal control or input.
- Government system can be the barrier, not the civil servants.
- RCAP recommendations were not implemented.
- INAC and Health Canada have confusing division of responsibilities.
- Federal government interventionist policy, third party management takes away power from local governments and federal Government formulas are not working.
- First Nations need to generate their own resources.
- Federal and provincial governments do not think that First Nations can take care of their own people, but the system is currently set up so that they cannot and when they try they fail. There is a need to build capacity.

There is/are:

- not enough innovation and creativity within policy
- lack of strong leadership, especially at the federal level that prioritizes Aboriginal issues
- need to delegate authority levels. All federal government decisions must be made in Ottawa. Local people cannot make any real decisions.
- need legislation for an Aboriginal- run health authority
- a lack of reliable database on Aboriginal statistics to help identify and address problems appropriately
- poor education in Aboriginal communities
- lots of rhetoric about working together but no concrete agreements and commitments; lack of true partnerships
- a lack of trust between all parties involved
- ongoing bureaucratic culture of control and complex structures
- a lack of efficiency within the health system and bureaucracies, especially with regard to transportation policies.
- a lack of economic opportunity on reserves, low levels of education among Aboriginal peoples, and limited training available on reserve
- a lack of acknowledgement of the importance of Aboriginal issues across all departments in government (lack of convergence)
- a need for creativity and innovation within bureaucratic structures
- racism inherent to ignoring Aboriginal issues, RCAP recommendations and the lack of funding– invisible holocaust
- no local decision making power

- a lack of Aboriginal control and input into policy – lack of self-government
- poor lifestyle choices and risky health behaviours of Aboriginal people
- general government preference for the existing order of things
- a lack of understanding, respect and inclusion of traditional healing in policy and services – no money for this
- no or very little beneficiary evaluation of health programs

Health Policy

- Federal health policy comes from Ottawa and has not evolved to include/reflect Aboriginal control or input.
- Remote communities still have poor access to services.
- Resources are wasted on transportation of patients off reserve; a need to offer more services locally, and better options for patients.
- Federal and provincial governments do not think that First Nations can take care of their own people, but the system is currently set up so that they cannot and when they try they fail. There is a need to build capacity.

There is/are:

- a lack of convergence (coordinated focus) to address issues
- poor lifestyle choices and health behaviors
- reduction of funding on health transfer agreements
- complex structural environment/bureaucracy
- general government preference for the existing order of things
- complex jurisdictional disputes over funding and responsibility

- a lack of understanding, respect and inclusion of traditional healing in policy and services – no money for this
- not enough Aboriginal health professionals
- no or very little beneficiary evaluation of health programs
- isolated communities and high transport costs
- little room for innovation and creativity within the federal government policy
- chronic disease increasing in Aboriginal populations and measures to stop this are failing
- a lack of cultural understanding and respect within health system

Aboriginal Policy/Politics

- Federal health policy comes from Ottawa and has not evolved to include/reflect Aboriginal control or input.
- Federal and provincial governments don't think that First Nations can take care of their own people, but the system is currently set up so that they cannot. When they try they fail. There is a need to build capacity.
- Aboriginal people need to take more responsibility for themselves.

There is/are:

- a need for self-evaluation processes to measure success of programs
- a lack of convergence (coordinated focus) to address issues
- poor lifestyle choices and risky health behaviors
- lack of Aboriginal control and input into policy – lack of self-government
- complex structural environment/bureaucracy
- desperate need for holistic approach to address lifestyle issues

- resources wasted on transportation of patients off reserve . A need to offer more services locally, and better options for patients
- community geographic isolation and high transport costs
- lack of Aboriginal pride in identity

Discussion of Barriers

Overwhelmingly, most barriers to positive change in Aboriginal health identified by the interviewees fall within the realm of public policy; in other words the policies, structures and beliefs maintained by the federal and provincial governments. Public policy barriers, particularly those identifying the federal government policies as problematic to improving Aboriginal health were identified more frequently by all interviewees than any other barriers. One interviewee said,

> We still need much more engagement of the federal government on these matters if we're to close the gap in the time frame that we said we could (in the Kelowna Accord). And Manitoba's committed to continuing to do that. And I think our only drawback and the only shortcoming we will have in achieving that, say, by 2016 is the degree to which the federal government will be an active partner – an active participant.[316]

All interviewees agreed that persistent jurisdictional disputes are one of the main barriers to improving Aboriginal health. Many interviewees remarked that though there is increasing awareness of this problem and that all parties are more willing to work together (for example within the ICFNH) it seems nearly impossible to change policy or implement action. One interviewee commented on these discussions about working together by saying, " it's all rhetoric – talk is cheap". This seems to boil down to two main issues for the interviewees; neither government (federal or provincial) wants to pay for Aboriginal health and neither government will acknowledge its legal obligation to

[316] Interview with an expert in Aboriginal Health, January 24, 2008.

provide services. One interviewee remarked on the ambiguity involved in the jurisdictional responsibility.

> It would have been so much better if it had said, yes, health is in here, or no it's not, or been no mention of it at all. Like either way....then it would have been so much better a 150 years later...but given that didn't happen, it was the federal government that signed the treaties. It wasn't the province that signed the treaties with the First Nations. That, you know given that (the federal government) still doesn't recognize health as a treaty right, - it just comes back down to, you know, what the feds think should happen versus what the provinces think should happen...There have been some inroads and some things have changed to a certain extent, but it is still very difficult to change anything.[317]

Several interviewees stated that it was puzzling that even in the face of financial analysis of the astronomical future costs related to Aboriginal health care if immediate investment is not made, governments continue to off-load responsibilities and withhold necessary funding.

> I think RCAP did a good job in that sense. If we could bring Aboriginal Canadians up to the level of other Canadians, it would save the system – what is it – 6.5 billion or something? I can't remember the number exactly but the number is there. And that the one I thought would be like a two-by-four between the eyes for policy makers. I thought; gee, when they see that they're going to know that they need to do something in this area. But that just seemed to go right by the accountants. You know, they're running the financial system. They're just looking at a year by year financial result on their estimates process, and, in fact, the federal government at the time, you, was adamant about just sort of shelving the report.[318]

Although both federal and provincial governments were identified as problematic, the interviewees overwhelmingly focused on the federal government policies as a barrier to improving Aboriginal health. One interviewee said,

> I think it's scandalous what the Feds have done. In the 90s they put a two percent cap on spending on reserve. And they've maintained it to this day. So over that time costs have gone up, populations have increased, and the result is that First Nations are squeezed more and more every year to try and meet the needs of their community with an ever reducing pie. You know, the pie has been shrinking

[317] Interview with an expert in Aboriginal Health, February 19, 2008.
[318] Interview with an expert in Aboriginal Health, January 24, 2008.

> every year since mid '90s. And that's scandalous. Absolutely scandalous....until the federal government gets past that myopic financial administrative way of looking at things, there's going to continue to be these conditions on reserve. I'm really surprised that it hasn't already been released or removed, because.....you know, Martin was no better than these guys (the current federal government). And...he claimed he wanted to close the gap, but that was an obvious area he could have addressed quickly, but he didn't. And the current government seems as determined as the previous ones to maintain that way of doing business. They keep talking about all the money that is already being spent. But when you look at it realistically, it doesn't make any sense.[319]

Lack of reciprocal accountability between Aboriginal communities and the federal government was raised by several interviewees as a barrier to health. There is an unbalanced focus on accountability in Aboriginal communities, but several interviewees said that the federal government is not accountable to Aboriginal people. There are almost no beneficiary evaluations of Aboriginal health programs, and when governments do not follow through on their commitments there is no mechanism to hold them accountable to the communities they are supposed to serve.

> The whole accountability issues had just been over – blown out of proportion....I think everybody recognizes that there is a need for accountability. But when I said blown out of proportion, it was just all these extra reports we've heard of, you know, that Auditor General spoke about them...And First Nations are asking, Well, where is the accountability on the federal government's part? And you know, now the big thing is to develop work plans. Well, where is your work plan? You know? You think they're going to answer that? No.[320]

Other public policy barriers that were mentioned by many interviewees were racist and discriminatory policy, refusal to hand over any real control of policy to Aboriginal people, lack of economic opportunities, and lack of resources to run programs or improve lives of Aboriginal people. Also mentioned by several interviewees was the

---

[319] Interview with an expert in Aboriginal Health, January 24, 2008.
[320] Interview with an expert in Aboriginal Health, April 8, 2008.

troubling lack of convergence between different levels of government and different government departments.

Health policy barriers that were identified by the interviewees focused mainly on the inadequacy of services available in remote communities and inadequate and inconsistent funding for health programs. All interviewees mentioned lack of Aboriginal control over health services and policy as a barrier to Aboriginal health. One interviewee said,

> It's not government edicts that will change people's habits and behaviours and eating. You know, family and diets and so on. It's where the community recognizes that this is something that they should be involved in and that take it up as part of their responsibility.[321]

Several interviewees said that there is not enough cultural understanding or holistic approaches involved in Aboriginal health policy and services, and that there is a desperate need for programs and policy that address lifestyle issues and health behaviors. Most interviewees saw the lack of flexibility in the current system as a significant problem. It leaves little room for the innovation needed to address the particular needs of communities.

Barriers to improving Aboriginal health within the realm of Aboriginal policy were not numerous. Generally interviewees had concerns over poor lifestyle choices and health behaviors, lack of self-government, and lack of pride in identity. One interviewee spoke about individual responsibility over health.

> I always say to people, how do you expect people to take individual responsibility when I'm a mother on the Reserve and I've got to feed my kid. They had a fight in school. School's shitty, My house is falling apart, My grandma's dying. Do you think I'm a mother who's a diabetic can look after myself? Unh-unh. I look after my family first. So you are up against all these challenges. It might be easy for you, a non-Aboriginal person to talk individual responsibility for health because

[321] Interview with an expert in Aboriginal Health, January 24, 2008.

> you have the resources. You have the gyms. You have the walk-ways to do that. You have access to healthy foods that are reasonably less expensive than what we would have in our communities.[322]

Several interviewees saw bureaucracy within Aboriginal organizations as a barrier, as well as the dependence on the federal government. One interviewee mentioned that First Nations organizations did not have adequate mechanisms for performance measurement and that this may be another barrier to improving Aboriginal health.

Conclusion

The results of the interviews highlight the fact that very few improvements have been made in the field of Aboriginal health since the release of the RCAP in 1996. The interviewees felt that RCAP had very little impact on the situation of Aboriginal people in Canada. The interview results have highlighted the intractable nature of the problems faced by Aboriginal people and the consistent lack of progress on improving this situation. Repeatedly, the interviewees identified lack of self-determination, lack of resources, racism, bureaucratic structures, and lack of federal commitment to address these issues as problems to improving Aboriginal health. An economic development strategy was seen by all interviewees as a way forward. One interviewee said,

> Well, I don't think you're going to close the health gap until you change the socio/economic circumstances of Aboriginal people. In order to do that, you know, obviously you have to focus on the reasons why Aboriginal people are not able to participate fully and benefit fully from the economy, and that relates to their skill level, and so we need to put a lot more emphasis on everything from early childhood education, early childhood development, to , you know, staying in school and graduating and post secondary education. And that will lead people to have a situation where they have choices. And it will also close the gap in terms of the income levels and economic circumstances which will contribute to better overall health circumstances. If people are making reasonable money, they can afford good housing, good food, recreation. You know, they can do all the things that are necessary to maintain and promote good healthy living.[323]

---

[322] Interview with an expert in Aboriginal Health, April 8, 2008.
[323] Interview with an expert in Aboriginal Health, January 24, 2008.

This viewpoint and the others reported above are not necessarily representative of all Aboriginal thinking on the issues and the knowledge base for those views has not been examined in depth. However, it is possible to claim that the respondents had significant involvement and experience with the issues at the heart of this thesis. The distinctive type of knowledge and opinion represented by their responses to the thesis questions captures a crucial reality in terms of a blend of facts, opinions and attitudes which federal and provincial governments and Aboriginal organizations must confront and deal with if they wish to achieve progress on Aboriginal health issues.

Chapter Seven will discuss the impact of RCAP and identify some possible explanations as to why change, so desperately needed, is so slow to develop. The chapter will consider the nature and extent of the problem set and explore possible policy implications and potential future policy directions.

Chapter Seven: Discussion of Results

Based on the findings of the research conducted for this thesis, this chapter will discuss the perceived impact of RCAP and define the problem set inherent to effecting positive change in the field of Aboriginal health. The chapter will identify possible policy implications and directions for Aboriginal health organizations, provincial and federal health policy, and the public, with respect to Aboriginal health care.

Perceived Impact of RCAP

The interview results discussed in the previous chapter clearly indicate that in general, the interviewees were of the opinion that RCAP had very little impact on Aboriginal health status, health services or health policy. Some interviewees felt that RCAP's main strength was as a comprehensive research document on Aboriginal history and current Aboriginal issues. Some felt that the RCAP report and process served to educate the Canadian public, although many felt that it had very little impact overall on the Canadian consciousness around Aboriginal issues.

The question remains, why has RCAP had very little impact? The most basic answer given in the interviews was that almost immediately upon its release the RCAP report was essentially 'shelved' by the Government of Canada. Even though there may have been a window of opportunity for comprehensive reform to Aboriginal-government relations when the commission was established, that window seems to have closed by the time that the bold, ambitious and expensive plan of the commission was released. The next logical question is why, after spending over $60 million dollars and numerous years on creating this massive and unique report, would the Canadian government choose to essentially ignore most of the recommendations? Several possible explanations exist.

The perceived lack of impact of RCAP may be related to the inherent nature of royal commissions. As discussed in Chapter Three, royal commissions are traditionally formed to address issues to which there are no easy, widely acceptable solutions. According to Bradford, while royal commissions have historically played a crucial role in introducing new and innovative policy ideas and increasing Canadian social learning about national objectives, they do not always lead to direct tangible policy change. During the 1990's many of the 'windows' for policy change were open. The problem stream, represented by the turmoil created by the events leading up to the RCAP, the policy stream and the politics stream were converging. However, in the field of Aboriginal health policy, there are so many layers of decision making and so many stakeholders, it makes policy change a very slow and difficult process. Both 'big' policy windows of opportunity that occur when the three streams converge at the national level and 'little' policy windows of opportunity when the streams converge at the local level must exist in order for change to occur. Therefore, there are limited windows for major policy changes. In the 1990's there was a window of opportunity for policy change, and this window resulted in the RCAP report. But this window may not have been large enough or been open long enough to gain the broad public and political support necessary to designate the required resources to implement the sweeping policy changes recommended in RCAP.

This leads to another question; why was there not enough public and political support to implement the RCAP recommendations? Were the recommendations inherently flawed? The results of the interviews indicate that in general, the recommendations were seen as important and sound. But they were not perceived as

viable. The exploration of the viability of the recommendations in previous chapters explained that in order for policy change to occur it must have political, economic and administrative viability. Many of the RCAP recommendations did not have political viability, meaning that the politicians of the time were not championing these issues. It is possible that politicians were not actively working to see these recommendations implemented because they were either unaware of the history, the gravity of the situation or the importance of addressing Aboriginal issues. It is also possible that politicians did not support and encourage the implementation of these recommendations because the Canadian public generally views Aboriginal issues as a 'special interest' area and do not see them as a priority for government spending. Earlier in the 1990s there appeared to be public and political recognition that the situation of the Aboriginal people was unacceptable and that something had to be done, although exactly what needed to be done was controversial within mainstream society and to a lesser extent among Aboriginal Canadians. RCAP was supposed to create greater public understanding of Aboriginal issues and problems, to identify possible solutions, build consensus in support of them and put pressure on governments at all levels to move beyond rhetoric to action. But the mandate was not there to allocate the necessary massive amounts of 'public' resources required to implement significant change. Therefore, the RCAP report has continued to be primarily a research document, not a framework for policy change.

Another reason why RCAP may have had minimal impact is that it called for sweeping policy change that Canadians and their bureaucracies were not ready to address. As we have discussed in previous chapters, Canadian public policy is generally quite slow to change. There is no doubt that the recommendations made in RCAP

differed greatly from the status quo. RCAP proposed change that would cost billions of dollars over approximately twenty years. The commission indicated it would be decades, if ever, for Aboriginal communities to become financially self-sufficient and not dependent on transfers in terms of money and services from other orders of government. The price tag for implementing the RCAP plan seemed astronomical at the time and there was little appreciation for the fact that governments would be saving money over the long term and reducing social misery, increasing social cohesion, avoiding potential social/political disruptions and avoiding international embarrassment which would occur if nothing was done of dollars over a period of twenty years, but that would ultimately save lives, and save Canadians money in the long term. The recommendations would have required public support, bureaucratic flexibility and organizational cooperation on a massive scale. The argument has been made by many observers that the RCAP recommendations were simply not viable because the political and administrative structures, accountability frameworks and capacity did not exist within the Canadian bureaucracy and especially within First Nations communities to practically allow for the level of autonomy and self-determination called for within the RCAP report. This is an important argument and one that held more weight at the time when the RCAP was released. However, twelve years later, very little has changed. Those twelve years could have seen a massive investment in building capacity among Aboriginal populations and improving the life chances and living conditions of Aboriginal people. However this massive investment has not happened. Programs like the Manitoba Framework Agreement Initiative that held such promise, were plagued with bureaucratic problems and were not given the resources necessary to properly achieve their goals[324]. Policy

[324] Winnipeg Free Press, *Who Set the Fire*, February 24, 2008, page B4.

remains, for the most part, unchanged and funding for Aboriginal issues is still inadequate.

The Problem Set

One of the key goals of this thesis is to establish the problem set around closing the gap between Aboriginal health and the health of other Canadians. The research and the interviews have shown that the problem set is complex and vast. In fact, the scope of this problem set is so large it would not be possible to definitely identify all the problems related to closing the health gap. However, it is possible to identify the key problems to closing the health gap and implementing positive change as discovered in the course of this research.

Essentially, Aboriginal health has not improved significantly since the release of the RCAP report because Aboriginal lives, education, economic opportunities and access to services have not improved to the extent necessary to impact health in a major way. Years after acknowledging in the RCAP report that the existing policies and practices related to Aboriginal health were not working, Canada still clings to the same ineffective policies and bureaucratic practices. This demonstrates the reluctance and refusal to change the way things are done by the people that control public policy and resources. Their reluctance to support necessary change in turn may reflect the fact that Aboriginal issues still rank relatively low on the political priority scale for most Canadians. The fact that Aboriginal policy has not changed significantly in Canada since the release of the RCAP, and that there continues to be grossly inadequate funding in all areas related to Aboriginal issues may send the message to Aboriginal people of Canada that their

problems, their situations and their very lives are not important to Canada. And so mistrust and resentment increase as the 'silent holocaust' continues.

The key barriers to positive change in the field of Aboriginal health discovered in the interviews and supported by the literature review are:

- Jurisdictional disputes and ambiguity over funding and legal responsibility for Aboriginal health
- Lack of Aboriginal control over health services and policy, ie: lack of self-government
- Continuing low socio-economic status of Aboriginal people in Canada
- Continuing poor lifestyle choices and health behaviours of Aboriginal people in Canada
- Continuing low levels of education of Aboriginal people in Canada, especially on reserves
- Continuing lack of adequate infrastructure on reserves (housing, roads, waste disposal, access to clean water), leading to health problems
- Continuing poor access to health services both in urban areas and on reserves
- Continuing treatment of Aboriginal people as if they were a special interest group, instead of acknowledgement that they never gave up jurisdiction
- Complex and inflexible bureaucratic structures that reflect the values of mainstream Canadian society
- Inadequate federal resources allocated to improving Aboriginal health

- Lack of political will and public support to implement major and necessary policy changes

Policy Implications

In consideration of the problem set, it is important to explore the implications for public policy, health policy and Aboriginal policy. If these are indeed the key problems, what needs to change in each of these areas to allow major positive change in the area of Aboriginal health?

Overwhelmingly, these problems are closely related to federal public policy. Many of the interviewees mentioned that there seems to be great fear of trying something new because it might fail. So instead, the federal government clings to the policies that have been proven inadequate. Many interviewees mentioned that one of the reasons it is so difficult to change the way things are done is because the federal government decision-making bodies are based in Ottawa and getting approval for anything new is a long and difficult process. This may mean that lowering federal decision making powers, perhaps to the regional level, could improve timelines on new initiatives. However, given the rigidity of the federal government, this lowering of the authority level seems unlikely, so perhaps having higher level decision makers involved in discussions around changing Aboriginal health service delivery and policy would be beneficial. Whatever the solution may be, it is clear that there is a great need for creativity, flexibility and innovation within the realm of Aboriginal health policy, and that this policy must reflect Aboriginal opinions, ideas and views.

Some of the other key problems, like low levels of education, income, employment and poor infrastructure are directly related to the socio-economic well-being

of Aboriginals. These issues are closely tied to both federal and provincial policies around resources, economic development and education. Results from the research point to the fact that increased autonomy, in other words some form of self-government along with a comprehensive economic development strategy, would offer ways to improve the socio-economic situation of Aboriginals in Canada. However, current public policy leaves very little opportunity for true self-government initiatives. The resources and opportunities are simply not currently available to Aboriginal people to effectively govern themselves or to take control over their economic futures as communities. There is clearly a need for more progressive public policy in the areas of self-government and control over resources.

One of the key reasons that public policy around Aboriginal issues has changed very little since the release of the RCAP report, is that there has been very little political will to implement the kind of change called for in the RCAP. The discussions around the Kelowna accord were quite promising, however the current minority Conservative Party of Canada (CPC) government at the national level has repeatedly criticized this accord, claiming that they have a better way to approach Aboriginal issues. However, the Harper government approach has been characterized by consistently disregarding the input of Aboriginal leaders and people while allocating very few resources to Aboriginal issues[325]. It seems that there is a desperate need for strong leadership in the area of Aboriginal issues at a high level within the federal government. In order for a politician to take up Aboriginal issues as their cause, they will likely either need to have a strong personal

---

[325] KAIROS: Canadian Ecumenical Justice Initiatives. *Canada's Aboriginal Policy: Discriminatory and Disingenuous. A Brief to the U.N. Committee on the Elimination of Racial Discrimination on the Occasion of the Examination of the Seventeenth and Eighteenth Periodic Reports Submitted by Canada. February, 2007.* http://www.kairoscanada.org/e/media/letters/aboriginalRightsCERD0702.pdf (accessed August 1st, 2008).

conviction about the importance of these issues or they need to be pressured by the Canadian public to make a significant and real change. In order for the public support to be there, there must be widespread and in depth education of Canadians on Aboriginal history and current situations. Changes to curriculum in schools could go a long way, but there is a much greater need to promote a fundamental understanding of the situation of Aboriginal people in Canada. There is a need to build trust between Aboriginal people and other Canadians. There is public opinion data on these issues which suggest that a majority of Canadians support the concept of self-government, but reject strongly the idea of separate laws for Aboriginal peoples. Both of these perspectives could be based on little actual knowledge of the issues and so would reflect existing prejudices and/or the images of the Aboriginal world presented in the media. Presumably such shallow opinions, supported by so little actual knowledge, can fluctuate greatly based on reactions to short-term, emotional events. There is a desperate need to openly acknowledge the reality of the widespread ignorance of Aboriginal realities and the hideous racism against Aboriginal people that still plagues Canadian society. When Canadians can embrace the fact that the well-being of Aboriginal people is a matter of national importance and a matter of human decency and social responsibility, then perhaps policies will change.

The problem set established has some significant implications for health policy. The results of the research indicate that access to health services continues to be a major barrier to improving Aboriginal health. This points to the fact that fundamental changes must be made to the way that health services are delivered to Aboriginal people. The RCAP offered recommendations on how Aboriginal health services could be restructured. Perhaps it is time to revisit those recommendations. There is a clear need for

increased Aboriginal representation in the area of health human resources. The research also indicates the holistic approaches to health are the most effective in Aboriginal communities and are the most consistent with traditional values. Empowerment at the community level may lead to improved health for Aboriginal people. Perhaps most importantly, jurisdictional disputes about responsibility and funding must stop. In order for this to happen federal, provincial and Aboriginal governments need to develop effective mechanisms for dealing with these disputes in the area of health.

Although the problem set does not include issues that Aboriginal political organizations have much direct control over, the problems certainly have implications for Aboriginal politics and Aboriginal policy. Strong leadership in the Aboriginal community may help to bring about positive change at a faster rate. By building capacity within their own communities and creating examples of successful self-government, Aboriginal people will make it more difficult for the governments to deny them the opportunity to govern themselves. Economic development is a key part of this process. Also needed is a campaign to promote understanding of the issues Aboriginal people face in order to educate the Canadian public. This is an area where Aboriginal organizations could play an important role. However, it is important to note that many Aboriginal political organizations and service delivery organizations rely on public funds. Any significant education initiative would need to be well funded and would require investment from all parties involved (federal and provincial governments included).

In order to effect change in any of these areas (public policy, health policy, and Aboriginal policy/politics), some of the key cross-cutting issues need to be addressed:

1) **Sovereignty/Self-government**

The research indicates that there is a desperate need for increased Aboriginal control. This would involve a form of self-government that is adequately supported with resources and capacity building. Evidence supports this. Chandler and Lalonde have found a close link between health status and self-government among First Nations communities. They conducted a study in British Columbia that found that cultural continuity acts as a protective factor against suicide in First Nations youth[326]. The fact that self-government has not happened in any meaningful way for most Aboriginal communities in Canada reflects the lack of public and political support for critical changes, which in turn reflects the need for widespread education and understanding of Aboriginal issues. The argument that the political, bureaucratic, administrative and accountability structures for self-government do not exist or that Aboriginal communities lack the capacity to govern themselves, simply cannot continue to stand as a valid excuse for clinging to the status quo. Aboriginal people must be give adequate resources to build capacity as well as the resources to be economically self-sufficient. It is essential to understand that public investment in Aboriginal people in the short term could lead to prosperity, sustainable self-sufficiency and better lives for Aboriginal people and all Canadians in the long term. It seems that there is a need to clarify the fact that Aboriginal prosperity and Aboriginal futures are inextricably linked to the prosperity and well-being of all Canadians. It is also important to acknowledge the inherent right of Aboriginal people to have more control over

[326] M.J Chandler and C.E. Lalonde. (1998). "Cultural continuity as a hedge against suicide in Canada's First Nations". [Electronic version]. In *Transcultural Psychiatry*, 35(2), 193-211.

their own futures through some form of self-government. Aboriginal self-government does not threaten the sovereignty of Canada as a nation. Canadian interests are not different from Aboriginal interests. This is where there seems to be devastating disconnect a persistent 'us and them' mentality.

There is a need for strong leaders to champion this cause at all levels within the Aboriginal communities, within provincial and federal governments. Strong leaders, particularly those with decision-making power, can bring about change very quickly. If Aboriginal issues have strong political support, they are more likely to get the attention and resources needed to bring about meaningful change.

2) **Culture – Racism and Discrimination**

From the limited and non-representative results of the interviews, it seems possible that within government and the civil service there is a common if not pervasive denial of the fact that policies, programs or government actions are racist. It is widely acknowledged by most people that the past actions of the government have been racist, but it seems that many public servants think that this systemic racism is a thing of the past. However, the interviews point to the fact that racism is obviously still one of the most critical issues in relation to Aboriginal health. Aboriginal organizations and elites clearly identified racism as a key barrier to improving Aboriginal health. The fact that racism was never identified by the non-Aboriginal interviewees may reflect the fact that they genuinely feel that they and other public servants and government officials are

doing their very best to create positive change for Aboriginal people. It seems likely that racism on an individual level is not so much the problem, but it is the system they are operating within. This system still views Aboriginal people as an interest group, particularly the umbrella organizations which represent Aboriginal peoples in the policy process throughout Canada. The alternative, competing vision is to see them as representatives of another nation which wants to deal government to government on matters of mutual concern. The system is still rooted in paternalism and does not acknowledge the Aboriginal right to govern themselves and does not provide the resources or the opportunities for them to do so. This is part of what one of the interviewees identified as the 'silent holocaust'. The researcher understands this phrase as an analogy meant to represent the fact that mainstream Canada does not listen to what the Aboriginal people are saying and does not pay attention to the devastating situations experienced by Aboriginal people. The often atrocious reality that Aboriginal people in Canada deal with on a daily basis escapes the attention of the Canadian public, and no matter how loudly Aboriginal people protest, it seems to fall on deaf ears. Policies don't change. Government actions and rhetoric seldom match as evidenced by their formulaic funding, devolution policies and lack of public education on critical issues, unbalanced focus on accountability, and rare instances of beneficiary evaluation of projects/programs. There is still a very pervasive 'blame the victim' mentality.

An important part of the culture issue is education. Every interviewee stressed the fact that education was an essential component of health, and that by

improving education Aboriginal health would improve. The need for education is not limited to a specific area. It refers to health education, academic education, skills training which leads to decent employment as well as educating the Canadian public on the history and reality of Aboriginal people in Canada.

3) **Structure**

Complex bureaucratic structures were repeatedly mentioned in the interviews and throughout the literature review, as a barrier to improving Aboriginal health. These structures are not easily simplified. What may be required to address this problem is a complete reorganization of the health system for Aboriginal people much like what was recommended in RCAP. One of the reasons that complex bureaucratic structures were seen as a problem was that they create numerous levels of administrations, control and therefore decisions take a very long time to be made and implemented. Perhaps a new form of Aboriginal self-government holds a solution to having to deal with the existing bureaucracies. However, it must be acknowledged that Aboriginal self-government also has the potential to add another layer of bureaucracy to an already Byzantine system of governance.

Another important component of structure is jurisdictional issues. All parties agree that persistent jurisdictional disputes are one of the central problems to implementing positive and effective change in the field of Aboriginal health. Jurisdictional ambiguities cause needless disputes. There is a clear need to define who is responsible for what and to align authority with resources as closely as possible so as to avoid the complications, limits on autonomy and blurred

accountability which accompanies joint or multiple orders of government, including Aboriginal governments operating in the same field. Although some groups like the ICFNH demonstrate the fact that all parties (federal, provincial and Aboriginal governments) are willing to sit down together and try to find solutions, the research shows that there is a desperate need for action, not just discussions. This action could take the form of concrete agreements and projects, innovation, flexibility, not just talk. It may be that a more incremental, step-by-step process based on an overall sense of direction specific improvements and real deadlines would realize more progress than an attempt to design and implement some 'grand design'. It is possible that political feasibility most often corresponds to smaller changes about which a consensus can be achieved. This being said, it is important to realize that there is not time and patience for a gradual and consensus-based approach after more than a century of racism, paternalism and neglect. Frustrations run rampant when elites discuss the turtle pace at which existing policies and programs can change, or new programs can be implemented. It seems that there is a need to lower the decision-making level to people on the ground not just those in Ottawa. There is also a need to make Aboriginal issues a priority across all government departments and for all Canadians. It is clear that the status quo for dealing with Aboriginal health has consistently been inadequate and is failing Aboriginal people. This needs to be acknowledged and new ideas, policies and programs that demonstrate innovative and creative ideas must take the place of the tired policies that consistently fail.

4) **Resources**

One of the reasons that Aboriginal health has been so slow to improve is that Aboriginal lives and socio-economic status have not significantly improved in the last twelve years. In a large part this is due to the fact that the federal and provincial governments, particularly the federal government, refuse to allocate adequate resources to Aboriginal economic development, education, health care, housing and infrastructure. The 2% federal cap on spending on reserves was described by one of the interviewees as 'unconscionable'. Aboriginal people currently lack the resources to implement effective economic development on their own. This lack of resources simply must change if we want to see an improvement in Aboriginal health. From a financial perspective, as laid out quite clearly in the RCAP report, it makes sense to invest in Aboriginal people now. A large scale investment, much like what was recommended by the RCAP has the potential not only to improve Aboriginal lives, but to make Aboriginal communities economically self-sufficient and to save Canadians billions of dollars in the future. Reluctance to invest resources in Aboriginal people now, seems to be based in adherence to status quo and fear that an investment in Aboriginal Canadians may take something away from other Canadians. This is short-sighted thinking and it is a key barrier to improving Aboriginal health.

The interviews and the research show that poor Aboriginal Health is largely due to the poor socio-economic conditions of Aboriginal people. In order for health to improve, these issues must be addressed. An economic development

strategy with adequate resources to support it would likely start to address and improve many of the underlying determinants of Aboriginal health.

Public policy, health policy and Aboriginal policy need to change in order for Aboriginal health to improve. But before change can happen it is necessary to face and deal with the cross-cutting issues and barriers, identified above. There are no easy solutions to improving Aboriginal health. Most importantly, the research reflects that policy must be flexible and allow for more Aboriginal ideas, input and control. Change at the level proposed by RCAP certainly cannot happen overnight, but no one is expecting that. The sad reality is that the RCAP report was released twelve years ago and very little has changed for Aboriginal people. We need to move toward change. We need less confusing bureaucratic structures. Health policy must be less formulaic and more needs based. Access to service must be improved, perhaps by providing more money for health professionals to travel to remote northern Aboriginal communities. Jurisdictional disputes must stop and there needs to be an effective mechanism for resolving these jurisdictional issues. Of course this begs the question of how. Aboriginal organizations need to work with governments to build capacity and develop resources. Most importantly all stakeholders need to be willing to try to implement new ideas. If these ideas fail, at least it would be better than trying the same methods that have been proven to be ineffective.

Conclusion

Twelve years after the release of the RCAP report, its recommendations are still relevant and have yet to be implemented. The problem set is much the same as it was in 1996. The situation for Aboriginal people has actually gotten worse in many ways,

especially the federal government's reluctance to empower First Nations, which is related to the complex nature of doing this, the bureaucratic culture of status quo, and possible deep-rooted subconscious notions that Aboriginal interests may conflict with Canadian interests. Canadians need to understand that Aboriginal issues are Canadian issues, and that improving the situation of Aboriginal people will improve life for all Canadians. The fact that racism is still perceived to be such a significant problem points the need for increased education and understanding and awareness of Aboriginal issues, not only among the Canadian public but among the Canadian political and bureaucratic elite. It is of paramount necessity to have convergence on all of the issues discussed in this chapter. No single area can make the difference to improving Aboriginal health. They all need to move forward together. This will require a massive investment much like what was called for in the RCAP report. This investment will not happen until it has the support of the Canadian people. It seems that in order to end the 'silent holocaust' experienced by Aboriginal people, we first must fight racism and increase cultural awareness and educate Canadians on the harsh realities of Aboriginal life in Canada.

Chapter Eight: Conclusions and Directions for Future Research

In Chapter One of this thesis, four key research questions were identified:

1. What is the current state of Aboriginal Health in Canada?
2. What were the key recommendations made by the RCAP report?
3. What are the perceived impacts of the RCAP on health care and policy in Manitoba?
4. What are the perceived barriers to the improvement of health policy and healthcare as they pertain to Aboriginal people in Manitoba?

These questions have been answered based on the results of an extensive literature review and the results of a series of elite interviews. This research will hopefully increase understanding of Aboriginal issues and health policy in Canada, as well as increase understanding of the role that royal commissions play in policy change.

This chapter summarizes the results of the exploratory research and identifies some of the challenges that must be addressed in the pursuit of improved health for Aboriginal peoples in Manitoba and Canada. The issues involved with all aspects of Aboriginal government relations and public policy towards Aboriginal peoples are inherently value laden, subjective and controversial. There is not even agreement on the past, let alone on what is wrong presently and on how things can be made better in the future. Most of the disagreement is between spokespersons for Aboriginal peoples and mainstream governments, but there are also significant divisions within Canadian society at large and even within Aboriginal communities which are diverse and at different stages of development. In the first seven chapters of this thesis, I have tried to keep my personal views out of the thesis, recognizing of course that what I chose to study, how I studied it

and what conclusions I drew from the evidence necessarily involved value judgments. From this point forward the thesis will reflect in an informed way, on the findings, and offer an increased personal interpretation on the issues. The chapter will then turn to an examination of the implications of the research for future investigation of the fields of Aboriginal health, health policy and health services.

Results to Key Research Questions

What is the current state of Aboriginal health in Canada?

The statistics included in the literature review show that Aboriginal health status is far below that of other Canadians. Although there may have been some gradual improvements over the last twelve years, the rapidly increasing rates of chronic diseases like diabetes among Aboriginal populations are a cause for great concern and reaching epidemic proportions. The poor health status of Aboriginal people is directly related to the continuing low socio-economic status of Aboriginal people in Canada. So long as Aboriginal people continue to have low levels of education, economic opportunity, employment, poor housing and related social problems of alcoholism, violence and crime, it seems likely that their health status will remain much lower than that of other Canadians.

What were the key recommendations made by the RCAP report?

The final report of the Royal Commission on Aboriginal Peoples was published in 1996, and included 440 recommendations and over 4000 pages. It contained 25 specific recommendations on how to improve the health of Aboriginal people in Canada. RCAP's proposed new approach to Aboriginal healing was based on four main principles: equity, holism, Aboriginal control and diversity. The RCAP health strategy had four pillars:

1. The restructuring of the current health system and the creation of system of health and healing centres and lodges under the control of Aboriginal people;
2. The creation and implementation of an Aboriginal human resources development strategy that would function within the new system;
3. The full support and cooperation of mainstream health service, training and professional systems;
4. A major infrastructure program to address serious environmental health threats in Aboriginal communities (clean water, safe waste management, and adequate housing).

While it is clear that the RCAP report contained numerous innovative recommendations and ideas for policy change in the area of Aboriginal health, an exploration of the political, economic and administrative viability of these recommendations has shown that it was unlikely that these new policy ideas and recommendations would be implemented immediately. The political viability of these recommendations may have been weak because politicians simply lacked the mandate from the Canadian people to allocate the massive resources to Aboriginal issues proposed in the RCAP. Another issue with the political viability of the RCAP recommendations was the nation-to-nation approach advocated by RCAP, which is rooted in the concepts of diversity and cooperation. Critics of the recommendations have pointed out that Canadian federalism is rooted in common standards and a uniform national civic status, meaning that the recommendations were unlikely to garner the political support necessary to be implemented. The RCAP recommendations placed heavy emphasis on the importance of self-government. It seems likely that the complexity and disputes

associated with self-government may have negatively affected the viability of the RCAP recommendations from an economic, political and administrative perspective. Many of the recommendations were not seen as economically viable, given the massive amounts of resources that would be required to properly realize them, especially at a time (the late 1990's) of tight budgets and fiscal constraint. Another strike against the RCAP recommendations was that the administrative structures for accountability and creating a whole new level of government simply did not exist at the time. Some critics claimed that this would end up adding another layer of 'burden' on public funds. As discussed in the analysis of the recommendations, it is important to note that while the recommendations of the RCAP may not have been viable at the time, it does not mean that they were not sound or necessary, just unlikely to be implemented.

What are the perceived impacts of the RCAP on health care and policy in Manitoba?

The results of the interviews indicate that RCAP had very little effect of Aboriginal health, health services or health policy in Manitoba. Most interviewees indicated that the report has been 'shelved' and that the recommendations have yet to be implemented. A few interviewees felt that the RCAP still held importance as a research document and a few mentioned that it may have played a role in increasing the public understanding around Aboriginal issues in Canada. Others stated that they felt that RCAP had done very little to improve the Canadian consciousness around Aboriginal issues. When assessing the impacts of royal commissions and other types of inquiries, it is necessary to distinguish the immediate, direct impacts on policy from the longer-term enlightenment function of such documents in terms of creating a climate of opinion

regarding particular issues and providing an agenda of ideas to which policy makers can return in the future when looking for ways to address enduring problems. Even twelve years after the release of the RCAP report it is not possible to offer a definitive assessment of its contribution to awareness and thinking about Aboriginal issues either among elite decision-makers, the interested segments of the public or Canadians generally. Awareness on all levels of the unacceptable conditions of Aboriginal peoples has increased, but the windows of opportunity for bold policy change which opened briefly in the mid-nineties seemed to be closed for the immediate future.

What are the perceived barriers to the improvement of health policy and healthcare as they pertain to Aboriginal people in Manitoba?

The literature review and the interviews revealed a complex web of barriers to improving Aboriginal health in Canada and Manitoba. All barriers must be addressed in a holistic way, through convergence across departments, governments and cultures, in order to bring about change. The key barriers identified in this research are:

- jurisdictional disputes and ambiguity over funding and legal responsibility for Aboriginal health;
- lack of Aboriginal control over health services and policy ie: lack of self-government;
- continuing low socio-economic status of Aboriginal people in Canada;
- continuing poor lifestyle choices and health behaviors of Aboriginal people in Canada;
- continuing low levels of education of Aboriginal people in Canada, especially on reserves;

- a lack of economic opportunities and employment, especially for Aboriginal populations living in smaller, remote northern and rural communities;
- despite rising Aboriginal consciousness, pride and nationalism, many Aboriginal people still must deal with racism and social stigma which weakens their sense of personal efficacy to confront the problems they and their communities face, including dealing with mainstream governments;
- a divergence between the Aboriginal conception of health which is more holistic and the mainstream conception which is focused on dealing with specific diseases;
- continuing lack of adequate infrastructure on reserves (housing, roads, waste disposal, access to clean water), leading to health problems
- continuing poor access to health services both in urban areas and on reserves;
- continuing treatment of Aboriginal people as if they were a special interest group, instead of acknowledgement that they never gave up jurisdiction;
- complex and inflexible bureaucratic structures that reflect the values of mainstream Canadian society;
- inadequate federal resources allocated to improving Aboriginal health;
- lack of political will and public support to implement major and necessary policy changes.

These barriers are all influenced and effected by cross-cutting issues. To overcome the barriers, these challenges must be addressed.

Sovereignty

In order to adequately address the issues of sovereignty and to correct the pervasive notion that Aboriginal issues are part of a 'special interest group', there must be education of the Canadian political and bureaucratic elites, as well as the Canadian public about Aboriginal history and current realities. There must also be education around potential solutions, costs and future projections and financial benefits to investing NOW. When Aboriginal health is prioritized by all Canadians, there will be potential to implement necessary changes. The literature review and the interviews emphasize that the importance of self-government to Aboriginal health should not be understated. Studies have shown that increasing the psychological sense of being in control of their own future and developing the political self-confidence to take charge of their personal lives and their community affairs can improve health. There is evidence that self-government in the educational field leads to higher high school graduation, among other improvements. It therefore seems likely that developing self-government strategies that will eventually lead to high levels of Aboriginal control over health services and health policy will ultimately contribute to improved levels of health among Aboriginal people in Canada[327].

Resources/ Fiscal Arrangements

Disputes over funding levels and arrangements as well as who controls resources, are the source of innumerable problems in the field of Aboriginal health. There is a need to determine an appropriate level of resources to devote to improving Aboriginal health. This is not something that can be decided by the federal or provincial governments

[327]M.J Chandler and C.E. Lalonde. (1998). "Cultural continuity as a hedge against suicide in Canada's First Nations". [Electronic version]. In *Transcultural Psychiatry*, 35(2), 193-211.

without the input and equal decision-making power of Aboriginal representatives. The federal and provincial governments have been determining this level of resources for years, and clearly have been coming up short.

In consideration of the fact that self-government is an important part of improving Aboriginal health, it will be important to address the economic self-sufficiency and sustainability of Aboriginal communities and governments. This will likely require new agreements to be made over the sharing and control of natural resources, in order to give Aboriginal people the tools they need to develop economically.

Accountability is another issue within the realm of fiscal arrangements and resources that will need to be addressed in order for new structures of governance and increased Aboriginal control over health policy and programs to occur. It seems to be universally accepted that accountability is necessary and important. However, when examining the actual small number but high profile cases of corruption and mismanagement in the Aboriginal community, it seems that the myth of Aboriginal profligacy is grossly over blown. This notion of Aboriginal incompetence, corruption or lack of accountability may be used as an excuse to maintain the status quo and not give real decision-making power to Aboriginal people. The results of the interviews strongly indicated that accountability must go both ways, not just Aboriginal people accounting to the federal government over how programs were administered and money was spent, but the federal government being accountable to Aboriginal people and organizations for their policies and services, and for the level of health care they provide. There is currently no real mechanism for this second kind of accountability which would reflect the fact that

in a self-government scenario, elected Aboriginal leaders would answer to their citizens in the same way that elected politicians do within the general Canadian political system.

Structure

The complex structure of the current bureaucracy around Aboriginal health seems to create barriers on many levels. Perhaps a restructuring of the bureaucracy of health for Aboriginals that involved a simplification and a rationalization of overlapping mandates would help to eliminate problems associated with the current bureaucracy including long delays, inflexible rules and regulations as well as culturally inappropriate policies. One of the biggest challenges laid out before all stakeholders in Aboriginal health, particularly within the bureaucracy, is overcoming the bias towards maintaining the status quo. One way to combat this problem may be to develop a framework for rewards and incentives for successful and innovative initiatives that result in positive change. Another essential step toward changing the status quo may be to increase Aboriginal participation in the design of and conduct of program and project evaluations.

Culture/Cultural

Culture is a key cross-cutting issue in the field of Aboriginal health and increasing cultural understanding may work to improve Aboriginal health status, health services and health policy. First, racism and discrimination were clearly identified within this research as barriers to improving Aboriginal health. These prejudices are deeply ingrained and likely result in part, from ignorance of the history and reality of Aboriginal Canadians. Action needs to be taken to mitigate or eliminate racism/discrimination against Aboriginal people. Increased understanding may also lead to increased public, political and economic support for new policy ideas in the field of Aboriginal health. Another

important aspect of culture is the systemic discrimination that exists within Canada. Systemic discrimination is usually taken to mean that structures and processes have a disproportionate and negative impact on a group within society, even though the structures and procedures are created and presented as neutral. This takes the form of formulaic funding, third party management, and devolution/transfer of services without adequate resources. In fact, resources adequate to the needs of Aboriginal people seem to be a low priority within the current system. When this changes, it is more likely that Aboriginal health will improve.

Culture may also play an important role in providing appropriate health services to Aboriginal people that reflect their traditional values and beliefs. Increasing cultural awareness of traditional beliefs and rebuilding cultural identity and pride in Aboriginal communities may also improve the well-being of Aboriginal communities and people. Increasing cultural pride and identity, which was essentially decimated by the Canadian government through the cultural genocide of residential schools, may help to increase self-esteem, which in turn may have a myriad of positive health benefits. An awakening of identity and pride is taking place already and the events which celebrate the positive features of Aboriginal culture are growing in number.

This research highlights the need to break the log-jam caused by these cross-cutting issues. Where should leadership come from? An examination of the cross cutting issues reveals that sovereignty, resources, and structure are all currently dominated by the federal and provincial governments. It seems likely that the Kelowna Accord was a missed opportunity which demonstrates the importance of political leadership. In spring 2008, the Council of the Federation consisting of the premiers and territorial leaders

called on the Harper government to return to the Kelowna agenda of reforms. Ironically, back in 1969 Aboriginal groups were fearful that the Trudeau white paper would hand them over to provincial governments. Now the provinces with the largest Aboriginal populations, including Manitoba, are taking the lead in promoting reforms across a number of policy fields. Given that the power and control still rests primarily with the federal and provincial governments, it seems logical that they have a responsibility to lead in the development of an effective process and/or effective action to change the status quo in the field of Aboriginal health. As evidenced by history, buy-in from the current power structure (those with political control and control over resources) is an essential condition for change in policy and practice to occur.

Aboriginal leadership could play an important role by highlighting the need for and by proposing options for processes and or actions that can be taken by the provinces and by the federal government to improve Aboriginal health. They may also play an important role by demonstrating how Aboriginal people can be an integral part of the process of change.

Once action and agreement on cross-cutting issues is underway, policies, programs and projects that address Aboriginal Health can be created and implemented without the burden and negative influences of the cross-cutting issues that currently block the way forward. Capacity development, socio-economic development, primary health care, and health services can then be implemented with a far greater chance of success. Lifestyle choices will likely improve with the increasing options available to First Nations people that come with socio-economic development. Significant levels of independence and self-government may help to develop a strong cultural identity and

pride for Aboriginal people within Canada. The question remains; how can all stakeholders, who have a long history of disputes and mistrust, overcome these challenges and find a way forward? The RCAP report did offer a way towards a healthier future for Aboriginal people and all Canadians. However, their recommendations were not perceived to be viable. Unfortunately, this research does not point to solutions. Hopefully, in establishing the problem set and identifying some of the key barriers to change, this research can highlight areas where future research may be conducted, which may in turn eventually offer solutions towards improving Aboriginal health in Canada.

The Implications for Future Research

- It may be very useful to study the reasons for the large gap in perceptions between Aboriginal elites in the field of Aboriginal health, and non-Aboriginal elites regarding racism and discrimination as barriers to improving health.
- Further research may be required to identify effective ways to educate the Canadian public as well as Canadian political and bureaucratic elite about Aboriginal history, current realities, racism, and discrimination. Promoting understanding is paramount.
- Further research should be done in the area of identifying processes that may be able to address problems within the cross-cutting issues of sovereignty, resources, structure and culture.
- Further research could be conducted into potential ways of achieving convergence on Aboriginal issues across government departments and between stakeholders. It seems that a coordinated focus on Aboriginal issues, particularly health, may be

more effective than the current fragmented approach to dealing with Aboriginal people.

- Identifying options for increasing the priority level of Aboriginal issues in government is necessary in order for significant changes in Aboriginal policy and services. This would include research into the political priority of Aboriginal issues and where they are in relation to other issues of national importance such as immigration, defense, industry, and justice.
- Innovative ideas around ways to achieving public support for a workable approach to Aboriginal Health improvement are needed. This would likely include research into self-government and widespread education of what self-government is and what it means for all Canadians.
- Further research into the relevance and longevity of royal commissions, and how to ensure that the results of the theses royal commissions have an impact on Canadian society. It is important to ask questions such as; Are there better alternatives to the generation of new policy approaches than royal commissions which by their very nature are episodic, one-time structures which take time to establish and dissolve once their reports are released? How have other proposed ideas worked, such as a permanent roundtable on Aboriginal issues that was proposed in a paper for the Aboriginal Justice Implementation Task Force, led by Paul Chartrand and Wendy Whitecloud?

Conclusion

The continuing poor health status of Aboriginal people in Canada compared to other Canadians is a black mark on the social fabric of Canadian society. The fact that this problem has existed for over a century and is not improving, is both shocking and unacceptable. The Royal Commission on Aboriginal People held the potential to address this problem and to find a path forward. Unfortunately for Aboriginal people, the recommendations made by RCAP have been largely ignored and very little has changed for Aboriginal people in Canada since the release of the report in 1996. The reasons for this are numerous and complex. It is possible that the RCAP marked a shift in Canadian thinking toward Aboriginal people and issues, a willingness to acknowledge the injustices of the past and the deplorable situations of the present. However, it seems that Canada, its governments and its people, still lack the willingness to dedicate the resources and make the major changes in policy that may be necessary to make a real improvement in Aboriginal lives.

It is clear that a major shift in thinking about Aboriginal health policy and services is necessary in order to improve this situation. The existing policies and programs are obviously failing to adequately meet the needs of Aboriginal people. The RCAP report clearly identified in 1996 that the system was failing. In many ways, Aboriginal health continues to get worse.

What is needed is leadership from all major stakeholders, especially leadership with the courage to explain that the Aboriginal health situation is largely the fault of ineffective and discriminatory government policies as well as mainstream Canadian society and its failure to examine in any serious way its own role in the problem.

Works Cited

Adelson, Naomi. "The Embodiment of Inequity: Health Disparities in Aboriginal Canada," *The Canadian Journal of Public Health 96*, supplement 2. (April 2005). http://www.cihr-irsc.gc.ca/e/documents/Volume_96-S21.pdf . (accessed 4 April 2008).

Arnason, Bruce. Interview by author, 11 January 2007, Gimli, MB, interview notes.

Arnason, Bruce. "Project Management in the Canadian Aboriginal Sector", Ph.D. diss., University of Bradford, 2001.

Assembly of First Nations, *First Nations Housing Action Plan 2005.* Website. http://www.afn.ca/cmslib/general/Housing-AP.pdf (accessed 4 April 2008).

Assembly of First Nations. *Royal Commission on Aboriginal People at 10 years: A Report Card*, (November 2006). Available from http://www.afn.ca/cmslib/general/afn_rcap.pdf (accessed 14 April 2008).

Attaran, Amir, and MacDonald, Noni. "Jordan's Principle, government paralysis", In the *Canadian Medical Association Journal*, (Vol. 177(4): 321, 14 August 2007. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1942093 (accessed 15 April 2008).

Barman, Jean. "The Legacy of Residential Schools and the Way Ahead." In *Visions of the Heart: Canadian Aboriginal Issues*, eds. David Alan Long and Olive Patricia Dickason. Toronto: Harcourt Brace & Company Canada Ltd., 1996.

Barnsley, Paul. *"Cree Chief Slams Gathering Strength"*, Windspeaker, (Ottawa, January 1999) http://ammsa.com/windspeaker/WINDNEWSJAN99.html#anchor199807 (accessed 11 April, 2008).

Boldt, Menno. *Surviving As Indians: The Challenge of Self-Government.* Toronto: University of Toronto Press Inc., 1993.

Bradford, Neil. *Commissioning Ideas: Canadian National Policy Innovation in Comparative Perspective*. Toronto: Oxford University Press, 1998.

Canada. *Census 2006 Aboriginal Peoples Highlights*. Ottawa: Statistics Canada, 2006. http://www.statcan.ca/Daily/English/080115/d080115a.htm (accessed 12 April, 2008).

Canada. *Early Responses to Romanow: Whose Views of the Future of Healthcare*? (PRB-02-26E, 3 December 2002). http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/EB-e/prb0226-e.pdf (accessed 13 April, 2008).

Canada. *Non-Insured Health Benefits Program Annual Report 2005-2006*. Ottawa: Health Canada, 2006. http://www.hc-sc.gc.ca/fnih-spni/pubs/nihb-ssna/2006_rpt/01_intro_e.html (accessed 30 March 2008).

Canada. *Report on the Commission on the Future of Health Care in Canada (Romanow Report)*. Ottawa: Health Canada, 2004.

Canada. *Report of the Royal Commission on Aboriginal Peoples.* Volume 1-5. Ottawa: Minister of Supply and Services Canada, 1996. http://www.ainc-inac.gc.ca/ch/rcap/sg/si15_e.html (accessed April 2008).

Canada. *Report of the Royal Commission on Aboriginal Peoples.* Word from the Commissioners. Ottawa: Minister of Supply and Services Canada, 1996. http://www.ainc-inac.gc.ca/ch/rcap/rpt/wrd_e.html (accessed 7 April 2008).

Canada. *The Well-Being of Canada's Young Children: Government of Canada Report 2006*. http://www.socialunion.ca/well_being/2007/en/chapter_8.shtml (accessed 30 March 2008).

Canadian Encyclopedia. *Royal Commission on Aboriginal Peoples*. http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=A1ARTA0011169 (accessed 6 April 2008).

Canadian Press. *Tories to Ignore Parliament's Kelowna Accord Vote.* (22 March, 2007). http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070321/kelowna_vote_070321/kelowna_vote_070321?s_name=&no_ads (accessed 13 April 2008).

CBC News. *Aboriginal Midwifery reclaims part of a lost culture.* (March 2006) http://www.cbc.ca/canada/manitoba/story/2006/03/01/win-Aboriginalmidwife060301.html (accessed 15 April, 2008).

CBC News. *Ottawa gets Failing Grade on Response to Aboriginal Commission.* (21 November, 2006). http://www.cbc.ca/canada/story/2006/11/21/grade-government.html (accessed 14 April 2008).

CBC News In Depth. *Native Rights Movement* (21 November 2006). http://www.cbc.ca/news/background/Aboriginals/native-rights-movement.html . (accessed 6 April 2008).

Centre for Aboriginal Health Research. *Evaluation of First Nations and Inuit Health Transfer Policy*. http://www.umanitoba.ca/centres/cahr/docs/health_transfer_exec_eng.pdf . (accessed 15 April 2008).

Chandler, M.J, and Lalonde, C.E. (1998). "Cultural continuity as a hedge against suicide in Canada's First Nations". [Electronic version] In *Transcultural Psychiatry*, 35(2), 193-211.

Community Futures Kitayan, *Oxford House First Nation.* Website. http://www.kitayan.ca/website/pages/oxford_house.html (accessed 3 April 2008).

Currie, R.J. "Report Summary based on the report: Needs-Based Planning for Manitoba's Generalist Physician". *Manitoba Centre for Health Policy Website.* http://www.umanitoba.ca/centres/mchp/reports/reports_94-96/surdocs.htm . (accessed 26 January 2007).

Cuthland, Doug. *Winnipeg Free Press*, A13, 5 December 2002. http://www.maeci-dfait.gc.ca/Aboriginalplanet/mission/mcps02november29-december05-en.asp?prn=1 (accessed 10 April 2008).

Dexter, Lewis Anthony. *Elite and Specialized Interviewing*. Evanston: Northwestern University Press, 1970.

Dickason, Olive Patricia. *Canada's First Nations: A History of Founding Peoples from Earliest Times.* Toronto: McClelland and Stewart Inc., 1992.

Dickason, Olive Patricia. *Recognized at Last? -- Some Reflections on the Royal Commission on Aboriginal People,* The Stanely Knowles Lecture, (22 October 1998, Waterloo University) http://economics.uwaterloo.ca/needhdata/dickason.html (accessed 11 April 2008).

First Nations and Inuit Health. *Website.* http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index_e.html ; (accessed 30 March 2008).

First Nations and Inuit Health Program Compendium. *Aboriginal Health Transition Fund (AHTF) and Aboriginal Health Human Resources Initiative (AHHRI).* http://www.hc-sc.gc.ca/fnih spni/pubs/gen/2007_compendium/5_infrastructure_e.html. (accessed 13 April 2008).

Fleras, A. "The Politics of Jurisdiction: Indigenizing Aboriginal-State Relations" In *Visions of the Heart: Canadian Aboriginal Issues*, eds. David Alan Long and Olive Patricia Dickason, 167. Toronto: Harcourt Brace & Company Canada Ltd., 1996.

Fox, Terry, and Long, David Alan. "Circles of Healing: Illness, Healing, and Health Among Aboriginal People in Canada." In *Visions of the Heart: Canadian Aboriginal Issues*, eds. David Alan Long and Olive Patricia Dickason. Toronto: Harcourt Brace & Company Canada Ltd., 1996.

Frideres, James. "The Royal Commission on Aboriginal Peoples: The Route to Self-Government?", In *Canadian Journal of Native Studies,* Vol. 16, No. 2, 1996, p. 247-266. http://www.brandonu.ca/Library/CJNS/16.2/frideres.pdf (accessed 8 April 2008).

"Gimli Doctors Return to Emergency On-call Rotations," *Interlake Spectator*, November 2005. http://www.interlakespectator.com/story.php?id=194449 (accessed 3 April 2008).

Hackett, Paul. "From Past to Present: Understanding First Nations Health Patterns in a Historical Context", in "Aboriginal Health Research and Policy: First Nations-University Collaboration in Manitoba," supplement to the *Canadian Journal of Public Health* 96, Supplement 1 (Jan-Feb 2005): S17-21.

Health Canada. *A Statistical Profile on the Health of First Nations in Canada.* Website. http://www.hc-sc.gc.ca/fnih-spni/pubs/gen/stats_profil_e.html (accessed 2 April 2008).

Health Canada, *Diabetes Among Aboriginal (First Nations, Inuit and Métis) People in Canada: The Evidence.* Website. http://www.hc-sc.gc.ca/fnih-spni/pubs/diabete/2001_evidence_faits/intro_e.html (accessed 3 April 2008).

Health Canada. *First Ministers Accord 2003: Factsheet.* http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/fs-if_1_e.html (accessed 13 April 2008).

Health Canada. *2003 First Minister's Accord on Health Care Renewal.* http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html (accessed 15 April 2008).

Health Canada. *First Nations and Inuit Health.* Website. http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index_e.html . (accessed 30 March 2008).

Health Canada. *First Nations and Inuit Health Benefits Information.* Website. http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestation/index_e.html . (accessed 30 March 2008).

Health Canada. *Healthy Canadians: a Federal Report on Comparable Health Indicators, 2002.* Website. http://www.hc-sc.gc.ca/hcs-sss/pubs/system-egime/2002-fed-comp-indicat/2002-health-sante2_e.html (accessed 2 April 2008).

Health Canada. *Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting.* (News Release 2004). http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_leaders-dirigents_e.html (accessed 11 April 2008).

Health Canada. *Ten Years of Health Transfer First Nation and Inuit Control*. Website. http://www.hc-sc.gc.ca/fnih-spni/pubs/agree accord/10_years_ans_trans/2_intro_e.html#Introduction (accessed 30 March 2008).

Health Canada. *Unintentional and Intentional Injury Profile for Aboriginal People in Canada*. http://www.hc-sc.gc.ca/fnih-spni/pubs/injury-bless/2001_trauma/5_dimension-aspect_e.html (accessed 18 April 2008).

Hurley, Mary, and Wherrett, Jill. *Brief regarding the report of the RCAP.* (Oct 1999, Government of Canada Parliamentary Research Branch PRB 99-24E). http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/EB/prb9924-e.htm#SOME%20MAJOR%20FINDINGS%20OF%20THE%20REPORT . (accessed 4 April 2008).

Indian and Northern Affairs Canada. *First Nations Housing*. Website. http://www.ainc-inac.gc.ca/pr/info/info104_e.html . (accessed 4 April 2008).

Indian and Northern Affairs Canada. *Housing and Infrastructure Inventory*, INAC, Manitoba Region. 2004.

Indian and Northern Affairs Canada. *Post-Secondary Education and Labour Market Outcomes Canada, 2001: Average and Median Incomes.* http://www.ainc-inac.gc.ca/pr/ra/pse/01/pt2-9_e.html (accessed 4 April, 2008).

Intergovernmental Committee on First Nations Health. *First Nations Health and Wellness in Manitoba: Overview of Gaps in Service and Issues Associated with Jurisdiction*. (2005). http://www.manitobachiefs.com/issue/health/First%20Nations%20health%20in%20Manitoba%20-%20final%20report%202005.pdf (accessed 14 April 2008).

KAIROS: Canadian Ecumenical Justice Initiatives. *Canada's Aboriginal Policy: Discriminatory and Disingenuous. A Brief to the U.N. Committee on the Elimination of Racial Discrimination on the Occasion of the Examination of the Seventeenth and Eighteenth Periodic Reports Submitted by Canada. February, 2007*.http://www.kairoscanada.org/e/media/letters/aboriginalRightsCERD0702.pdf . (accessed 1 August 2008).

Kanesatake, *The Summer of 1990* http://www.kanesatake.com/heritage/crisis/media.html. (accessed 6 April 2008).

"Kids' Fund Sends Food North," *Winnipeg Free Press*, 25 January 2006, B3.

Malloy, Jonathan. "Double Identities: Aboriginal Policy Agencies in Ontario and British

Columbia". *Canadian Journal of Political Science* 34, No. 1 (Mar., 2001): 131-155.

Manitoba Aboriginal and Northern Affairs . *Report on Aboriginal People in Manitoba: 2000.* Website. http://www.gov.mb.ca/ana/apm2000/1/n.html (accessed 2 April 2008).

Manitoba Centre for Health Policy, *Comparative Indicators of Population Health and Health Care Use for Manitoba's Regional Health Authorities, 1999.* Website. Available from http://www.umanitoba.ca/centres/mchp/reports/pdfs/rha.pdf . (accessed 3 April 2008).

Manitoba Centre for Health Policy. *Health and Healthcare Use of Registered First Nations People Living in Manitoba: A Population Based Study.* Website. http://www.umanitoba.ca/centres/mchp/reports/pdfs/rfn_pdfs/rfn_ch04.pdf . (accessed 2 April, 2008).

Manitoba Government. *Regional Health Authorities.* http://www.gov.mb.ca/health/rha/index.html (accessed 13 April 2008).

Manitoba Government. *Report of the Manitoba Regional Health Authority External Review Committee* (February 2008) http://www.gov.mb.ca/health/rha/docs/report0208.pdf (accessed 13 April 2008).

MB Telehealth. *Website.* http://www.mbtelehealth.ca/faq.php (accessed 15 April 2008).

Martens, Patricia et.al. "Health and Healthcare Use of Registered First Nations People Living in Manitoba: A Population Based Study". *Manitoba Centre for Health Policy Website.* March 2002 http://www.umanitoba.ca/centres/mchp/reports/rfn_pdfs.htm (accessed 2 April 2008).

Martens, PJ, Sanderson D, Jehamani LS. (2005*) Mortality Comparisons of First Nations to all Other Manitobans : A provincial Population-based Look at Health Inequalities by Region and Gender*, Canadian Journal of Public Health, (Volume 96, 33-35).

McCaskill, Don, *Manitoba Framework Initiative Review Final Report, 1999.* http:www.aina.gc/pr/pub/ae/re/98-04/98-04_1_ehtml (accessed 9 April 2008).

McFarlane, Peter. "Aboriginal Leadership." In *Visions of the Heart: Canadian Aboriginal Issues*, eds. David Alan Long and Olive Patricia Dickason. Toronto: Harcourt Brace & Company Canada Ltd., 1996.

McGill Reporter, *Royal Commission on Aboriginal Peoples: Will study bring sweeping*

change or prove costly exercise in futility? (Volume 29 - Number 10 - Thursday, February 13, 1997). http://reporter-archive.mcgill.ca/Rep/r2910/Aboriginal.html (accessed 8 April 2008).

McMillan, Alan D. *Native Peoples and Cultures of Canada.* Toronto: Douglas and McIntyre, 1988.

Monture-Angus, Patricia A. "Lessons in Decolonization: Aboriginal Overrepresentation in Canadian Criminal Justice." In *Visions of the Heart: Canadian Aboriginal Issues*, eds. David Alan Long and Olive Patricia Dickason. Toronto: Harcourt Brace & Company Canada Ltd., 1996

National Aboriginal Health Organization, *Release of 2006 Census Data Continues to Tell the Story of First Nations, Inuit and Métis Health and Well-being* . Web site. http://www.naho.ca/english/newsReleases/01_15_2008.pdf (accessed March 30, 2008).

Neville, Anita. *Tories Shamefully Playing Petty Partisan Games and Ignoring Serious Issues.* (8 February 2008). http://www.anitaneville.ca/2008_02_01_archive-news.html. (accessed 13 April 2008).

Notes on Elite Interviewing, EPIC Workshop, Florence, May 2002. http://www.lse.ac.uk/collections/EPIC/events/Interviewing.pdf (accessed 17 April 2008).

Nowegesic, E., and Reading J. "Improving the Health of Future Generations: The Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health" *American Journal of Public Health* 92 no. 9 (September 2002): 1396.

O'Reilly, Michael. "Hunger Strikers Protest First Nations Health Care." *Canadian Medical Association Journal* 160, no. 11 (1999).

Pan American Health Organization, *Major Trends in Health Legislation in Canada 2001-2005,* (November 2006). http://www.ops-oms.org/english/DPM/SHD/HP/health-legislat-trends-CAN05.pdf (accessed 13 April 2008).

Pinette, Dr. Giles. *Should we Treat Aboriginal People Differently*? Presentation at the University of Manitoba. February 11 2004.

Romanow, Roy. *Building on Values – The Future of Health Care in Canada.* http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf . (accessed 16 April 2008).

Service Canada. *Aboriginal People in Manitoba.* (2006) http://www1.servicecanada.gc.ca/en/mb/Aboriginal-profile/Aboriginals.pdf . (accessed 18 April 2008).

Statistics Canada. *Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census* . Website. http://www12.statcan.ca/english/census06/analysis/Aboriginal/children.cfm . (accessed 30 March 2008).

Statistics Canada. *Aboriginal Peoples Survey 200* .Website. http://www.statcan.ca/english/freepub/89-589-XIE/89-589-XIE2003001.pdf . (accessed 3 April 2008).

Statistics Canada. *Aboriginal Population by Province and Territory.* (Census 1996) http://www40.statcan.ca/l01/cst01/demo40c.htm (accessed 17 April 2008).

Statistics Canada. *Canada's Changing Labour Force, 2006 Census: The provinces and territories.* Website.http://www12.statcan.ca/english/census06/analysis/labour/ov-cclf-26.cfm . (accessed 4 April 2008).

Statistics Canada. *Census 2001.* Website. http://www12.statcan.ca/english/census01/home/index.cfm (accessed 30 March 2008).

Statistics Canada, *Census 2006, Website.* http://www.gov.mb.ca/asset_library/en/statistics/north.pdf (accessed 3 April 2008).

Statistics Canada. *Educational Portrait of Canada, Census 2006.* Website. http://www12.statcan.ca/english/census06/analysis/education/pdf/97-560-XIE2006001.pdf (accessed 4 April 2008).

Statistics Canada. *Health of the Off Reserve Aboriginal Population* (The Daily, Tuesday August 27, 2002). http://www.statcan.ca/Daily/English/020827/d020827a.htm . (accessed 4 April 200).

Statistics Canada. *Size and Growth of the Population by Aboriginal Identity, Canada, 1996 and 2006.* (Census 2006) http://www12.statcan.ca/english/census06/analysis/Aboriginal/surpass.cfm. (accessed 17 April 2008).

The Free Library. *House Unanimous in Support of Jordan's Principle.* http://www.thefreelibrary.com/House+unanimous+in+support+of+Jordan's+principle.-a0174281129 (accessed 15 April 2008).

Thomas, Paul. "Challenges of governance, leadership and accountability in the public sector" 128. In *Change in Public Services,* eds. Wallace, Michael, Michael Fertig and Eugene Schneller(eds.) *Change in Public Services.* London , Blackwell, 2007 pp.116-134.

Town of Gimli, *Health Services* . Website.
http://www.gimli.ca/services/services_det.asp?ID=16 (accessed 3 April 2008).

Treasury Board of Canada Secretariat, *Canada's Performance Report 2004.*
http://www.tbs-sct.gc.ca/report/govrev/04/cp-rc5_e.asp. (accessed 18 April 2008).

Treasury Board of Canada Secretariat. Canada's *Performance Report 2005.*
http://www.tbs-sct.gc.ca/report/govrev/05/ann304_e.asp . (accessed 19April 2008).

Tuohy, Carolyn Hughes. "The Costs of Constraint and Prospects for Health Care Reform in Canada," In *Health Affairs: The Policy Journal of the Health Sphere*
http://content.healthaffairs.org/cgi/content/full/21/3/32 (accessed 1 August 2008).

University of Calgary Gauntlet. *First Nations Chief Calls for Government Action.* March 8, 2007). http://gauntlet.ucalgary.ca/story/11144 (accessed 14 April 2008).

Ware, Allan and Sánchez-Jankowski, Martin. *Elite and Specialized Interviewing (introduction).* http://www.essex.ac.uk/ecpr/publications/chapter/Dexter-Sample-Chapt.pdf (accessed 18 April 2008).

"When it comes to alcohol, it's time to start discriminating against Aboriginals." *Report Newsmagazine,* Alberta Edition 28 no. 8 (April 2001): 30.

Wherrett, Jill. "The Research Agenda of the Royal Commission on Aboriginal Peoples", In *Canadian Public Administration,* Volume 38, No.2 (summer) p 272-282.

"Who set the fire? $55 million up in smoke on self-government initiative" *Winnipeg Free Press*, (February 24, 2008): B4.

York, Geoffery. *The Dispossessed: Life and Death in Native Canada.* Toronto: McArthur and Co., 1990.

Appendix 1: Interview Protocol and Questions

Introduction:

Interviewer introduces herself to the interviewee and provides a brief background on the topic as follows:

Purpose: to familiarize the interviewee with the topic of the thesis and the high-level goals of the interview.

1) **Could you give me a brief explanation of your involvement in the field of Aboriginal Health.**

Purpose: to clarify their experience in this area and the roles they have played, projects they have participated in etc. This will help contextualize their opinions, and may facilitate easier analysis of the interview.

2) **One of the key goals of this research is to identify interviewee perceptions regarding major changes in the Aboriginal Health Status, Health Services and Health Policy since the release of the RCAP report in 1996.**

- **In your opinion have there been any significant changes in Aboriginal Health Status since the release of the RCAP report in 1996?**
    - Which of these changes do you believe have been positive changes for aboriginal health status-outcomes?
    - Please identify any changes that have been negative or created significant difficulties in improving aboriginal health outcomes
    - In your opinion, what are the most important areas where major work is required to effect positive change in Aboriginal Health Status?

- **In your opinion have there been any significant changes in the nature or delivery of Aboriginal Health Services since the release of the RCAP report in 1996?**
    - Please identify positive changes
    - Please identify negative changes
    - In your opinion, what are the most important areas where major work is required to effect positive change in Aboriginal Health Status?

- **In your opinion have there been any significant changes in Aboriginal Health Policy or policy directions since the release of the RCAP report in 1996?**
    - Please identify positive changes
    - Please identify negative changes

- Please describe what you would perceive to be positive change in Aboriginal Health Policy?
- In your opinion, what are the most important areas where major work is required to affect positive change in Aboriginal Health Policy?

Purpose: to outline any significant changes they have perceived in Aboriginal health status, services and policy since 1996. Follow up questions (included above) will help determine whether these changes have been positive or negative, and other areas where major work is required.

3) **To what extent do you think that RCAP has been responsible for influencing these changes?**

Purpose: to determine their perception regarding RCAP's role in regards to change in Aboriginal Health status, services and policy.

4) **There were 4 key elements to the Health Strategy recommended in the RCAP report. In your opinion, how realistic/viable (politically, structurally, administratively, culturally) were the health related recommendations of the RCAP report? What about the broader (non-health related) recommendations**
   - the reorganization of health and social service delivery through a system of healing centres and lodges under Aboriginal control;
   - an Aboriginal human resources development strategy;
   - adaptation of mainstream service, training and professional systems to affirm the participation of Aboriginal people as individuals and collectives in Canadian life and to collaborate with Aboriginal institutions; and
   - initiation of an Aboriginal infrastructure program to address the most pressing problems related to clean water, safe waste management, and adequate housing.

Also consider these recommendations:

Recognition of health of a people as a core area for the exercise of self-government

Develop a framework whereby agencies mandated by Aboriginal governments can deliver health and social services under provincial or territorial jurisdiction

Adapt FPT legislation, regulations and funding to promote integrated service delivery, collaborative FPT and local efforts in health services, and pooling of resources from FPT, municipal or Aboriginal sources

Formation of regional Aboriginal planning bodies in new areas to promote equitable access to appropriate services and strategic deployment of resources.

What about the broader (non-health related) recommendations? IE – has there been any fundamental change in the structure of the relationship between First Nations and the Canadian government, as recommended in RCAP? What about creating a Canada wide framework agreement to guide treaty negotiations? What about recognition of the scope and inherent right of Aboriginal self-government Recognition of Aboriginal governments as one of three distinct orders of governance in Canada, and type/scope of financing arrangements? Development of FPT long term economic development agreements with Aboriginal nations or institutions? Establishment or strengthening of Aboriginal institutions for the management and development of Aboriginal lands and resources?

Purpose: to determine interviewees perceptions regarding the viability of the RCAP recommendations

5) **What impact do you think the RCAP has had on key stakeholders working to improve aboriginal health?**

Purpose: to determine interviewee's opinion of the purposes, advantages and limitations and likely effectiveness of Royal Commissions

6) **What do you see as the most significant obstacles and barriers to implementing positive change in :**
   a)Aboriginal health status,
   b) Aboriginal health services
   c) Aboriginal health policy policy?

Purpose: to identify the problem set around closing the health status gap, improving Aboriginal Health services and creating more effective Aboriginal Health policy.

7) **What are your opinions about local control and influence over**
   a) **Health status**
   b) **health services**
   c) **health policy**
   d) **Can you give examples of positive and negative aspects of local control.**

Purpose: to identify the strengths as weaknesses of local control over health services

8) **The literature on Aboriginal Health in Canada often refers to jurisdictional issues and disputes as a potential problem. In your experience have you found this to be true? (ask this only if they have not already identified it)**

Purpose: to identify the interviewee's opinion on the role of jurisdictional conflict in the field of Aboriginal health

9) **What role does culture (Aboriginal culture, mainstream Canadian culture or other) play in the pursuit of improving Aboriginal health status, services, and creating better policy?**

Purpose: to determine their opinion on how culture and cultural differences may or may not influence change in status, service and policy.

10) **What is your opinion regarding the role of government bureaucracies and organizations (federal, provincial and first nation) in the efforts to effect positive change for:**
    a) **Aboriginal health status**
    b) **Aboriginal Health Service delivery**
    c) **Aboriginal health policy**

What are strongest negative things about the bureaucracies-organizational structures referred to above?
What are the strongest positive things?
In your opinion what changes to bureaucracies -structures would be most likely to improve aboriginal health status?

Purpose: to see if the interviewee thinks that complex bureaucratic structures and time delays contribute to the ongoing health gap because change is so slow to occur – takes forever to get anything done, once decisions are made, structures and people have changed, a lot of work is lost

11) **In your opinion in what areas is there consensus between the major stakeholders on the policy direction and objectives in relation to Aboriginal Health? In what areas are there conflict –difficulties or lack of consensus among the major stakeholders. What role does this play in affecting change?**

Purpose: to determine if the interviewee believes that the objectives of all stakeholders (Aboriginal groups, provincial government, federal government, general Canadian public) are the same or compatible. If they are not the same, is this one of the major barriers to positive change?

12) **In your opinion how can the barriers to change that you have identified during this interview be dealt with in order to close the health gap between Aboriginal people and the rest of Canadians?**

Purpose: to confirm their perceived barriers to change, to illicit opinions on the future of Aboriginal Health Status, Services and Policy, and to generate some ideas about more effective ways to close the health gap.

13) Are there any other comments or issues that you feel are important to progress in the field of Aboriginal Health? Can you identify any areas where more research needed?

Appendix 1: Consent Form

Research Project Title:	The Perceived Impact of the Royal Commission on Aboriginal People on Aboriginal Health, Health Services and Health Policy in Manitoba
Researcher:	Freyja Arnason, Master of Arts student at the University of Manitoba
Institution:	University of Manitoba

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The purpose of this research is to provide a portrait of the perceived impact of the Royal Commission on Aboriginal People (RCAP) on health policy and systems in Manitoba, through a series of interviews with experienced people in the field of Aboriginal Health in Manitoba. The researcher also seeks to identify any perceived barriers to major improvement in the field of Aboriginal Health in Manitoba and through the analysis of these perceptions seeks to outline the problem set involved in developing and choosing policy options for Aboriginal health care and services in Manitoba.

The interviewer will ask the interviewee to share his/her opinion and perceptions regarding the nature of Aboriginal health, health services and health policy in Manitoba and regarding the RCAP. The interviews shall last approximately one hour. Upon consent, the interviews will be recorded with a small tape recorder.

Confidentiality will be maintained before, during and after the research is conducted. No research subject shall be named in any published work arising from this research including the thesis itself. Only the researcher and the thesis advisor shall have access to the subject's identities and no interviewee will be identifiable from the information presented in any publication. A copy of the final thesis will be provided to the interviewee by the researcher by mail or email. Participants may withdraw from the study at any time without penalty or consequence.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you

should feel free to ask for clarification or new information throughout your participation.

Researcher: Freyja Arnason (204) 285-7788
Supervisor: Professor Paul Thomas (204) 474-8116

This research has been approved by the Joint-Faculty Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail margaret_bowman@umanitoba.ca . A copy of this consent form has been given to you to keep for your records and reference.

_____

Participant's Signature Date

_____

Researcher's Signature Date