

Mino Pimatiseewin:
A Content Analysis of the
Aboriginal and First Nations Submissions
to the
Commission on the Future of Health Care in Canada

By Rose McIvor-Girouard

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

MASTER OF SOCIAL WORK

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In Memory of

My parents,

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Abstract

This research supports the assertion that First Nations peoples and their organizations have suggestions and potential solutions for addressing the future of health care in Canada as it relates First Nations Canadians. First Nations understand and know what changes are needed to improve their poor health status within Canada. This research, based on a First Nation perspective, used content analysis to explore the needs identified by the First Nations organizations that responded to the Commission on the Future of Health Care in Canada (the Romanow Commission). The Romanow Commission was established in April 2001 and one element of its mandate was to engage Canadians in a national dialogue on the future of health care and make recommendations to the health care system. This research examined the written submissions to the Romanow Commission by the thirty-two (32) Aboriginal organizations. The main interest and focus of this research was on the written submissions of eighteen (18) First Nations organizations.

The Aboriginal Life Promotion Framework (Bartlett, 2004) was developed by a Metis woman and sensitized the researcher in the direction and organization of the research data. The research analysis revealed twenty-one (21) themes among the Aboriginal submissions. Four (4) of these themes were common to all five identified Aboriginal categories [First Nations, Inuit, Metis, Metis & Aboriginal, Aboriginal Interest/Focus] created by the researcher to assist in the organization of the research data. The researcher examined these four themes with the major focus being First Nations health concerns with respect to: (1) relationships with federal and provincial governments; (2) policy and program development; (3) fiscal resources; and, (4) accessibility issues.

This research found First Nations did not echo the same approach to change the health care system as the Romanow Commission did in its final report regarding Aboriginal Health. It is important for First Nations people to put forth their own ideas about the direction for First Nations health to offset the pan-Aboriginal approach that the Romanow Commission has offered. Therefore, this research supports the need for increased participation by First Nations peoples, including their respective governments and First Nations health organizations in health research. From their own perspectives, First Nations identified their own solutions, which they believe may likely lead to a better health care system for First Nations. This research has advocated for the future development of a “Miõo Pimâtisiwin or Mino Pimatisiwin First Nations Conceptual Framework” developed by First Nations for First Nations Health Research. “Mino Pimatisiwin” in the Swampy Cree language [Miõo Pimâtisiwin in the Woodlands Cree] translated infers the meaning “good survival/living, “healthy survival/living”. The results of this research will be of interest to those engaged in policy development as it relates to First Nations health.

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I. INTRODUCTION

This research focused on what First Nations¹ wanted from Canada's health care system. First Nations health status remains "deficient relative to the general population" of Canada (Helin, 1993, p.158; Assembly of First Nations, [AFN] 2002; Metis National Council [MNC], 2002). This research examined what First Nations stated they wanted changed in Canada's health care system in 2001 – 02. First Nations provided recommendations regarding the health care system to the Commission on the Future of Health Care in Canada (the Romanow Commission). This research found First Nations firmly believe that they know what needs to be changed in the health care system.

In 2001, The Government of Canada established the Romanow Commission to review medicare, to engage the Canadian public in discussion about the health care system throughout the country. The Commission was charged with responsibility to make recommendations to enhance the system's quality and sustainability and to outline policies and measures that would ensure the long-term sustainability of a universally accessible, publicly funded health care system. (Romanow, 2002) The Romanow Commission provided Aboriginal people² a national venue to express what changes they wanted from Canada's health care system. Across Canada, various First Nations organizations participated in the Romanow Commission; they voiced concerns about issues affecting First Nations regarding Canada's health care system. The recommendations put forward by First Nations were efforts to possibly address the continued concerns regarding the poor health status of First Nations, a fact often cited in

¹ The term, First Nations in this research is interchangeably used with the term "Indian" which refers to individuals that have a right to be registered under Indian Act of Canada.

² The term Aboriginal is used as outlined in the Canadian Charter of Rights and Freedoms: Aboriginal people are Indians defined under the Indian Act, the Metis and the Inuit of Canada.

literature. (Helin, 1993; Royal Commission on Aboriginal People [RCAP], 1996, Romanow, 2002).

First, the purpose of this research was to identify what First Nations people wanted from Canada's health system in 2001 – 02. The main research activity entailed a content analysis of documents submitted by various Aboriginal organizations to the Romanow Commission. The research used an Aboriginal conceptual framework, the Aboriginal Life Promotion Framework (ALPF) developed by Judith Bartlett to examine the submissions of Aboriginal organizations. (Bartlett, 2004, p. 154).

Second, the purpose of this research was to make a First Nations contribution to Aboriginal health research and to influence future policy direction on First Nations health in Canada. I firmly believe that “we” as First Nations people determine our own course of life and determine what makes sense for us in health care. First Nations people need to continue to advocate for change to address the health status gap in Canada. I have direct experience with the health care system as a First nation woman. Issues related to access, portability, and navigation within the health system has been difficult. This research was an effort to advocate for change to improve the health services to First Nations in Canada.

This report includes some review on Canada's health care system, the duties of the Commission on the Future of Health Care in Canada, and Aboriginal/First Nations participation in the Romanow Commission. There is a discussion about the cultural context of Aboriginal health and the Aboriginal Life Promotion Framework (Bartlett, 2004) presented. This framework was used as a sensitizing framework for the researcher. A content analysis of the Aboriginal submissions to the Romanow Commission was undertaken. Themes are identified and recommendations put forward with respect to

First Nations health. The value and contribution of this work to the social work is discussed in the final chapter.

II. LITERATURE REVIEW

This literature review consists of two parts as follows. The first part discusses the Canada's health care system, the Commission on the Future of Health Care, Aboriginal participation in the Romanow Commission, and First Nations health status. The second part identifies the cultural context of health and presents an Aboriginal conceptual framework.

i. Canada's Health Care System

Canada has a publicly funded health care system. The health care system is guided by the following principles: public administration, comprehensiveness, universality, portability, and lastly, accessibility. (Health Canada, 2004) Public administration means the health care delivery is administered and operated by a public authority, and the provincial government is responsible for health care administration. Comprehensiveness means that provincial health care insurance plans insure that "medically necessary hospital services, physical and surgical-dental services are provided to the insured persons." (Health Canada, 2002) Universality states that all residents except the Canadian Forces, the Royal Canadian Mounted Police [RCMP], and federal prisoners are entitled to provincially insured health services. The federal government's role in health care is to provide services directly to the following, veterans, First Nations living on reserve, the military, the RCMP, and federal prisoners. Portability allows the province's health insurance plan to continue to cover a resident temporarily traveling outside of their home province. There are some categories of resident, which require a waiting period before they can receive health care services. Accessibility requires that health care delivery be without discrimination based on age, lifestyle or health status;

services should be available at a comparable level for all Canadians. (Health Canada, 2004)

First Nations organizations continue to question whether these principles have made their way into First Nations communities. Evidence of this position was noted in First Nations submissions to the Romanow Commission. (AFN, 2002; Assembly of Manitoba Chiefs [AMC], 2002; Dakota Ojibway Tribal Council [DOTC], 2002; Romanow, 2002, Southern Chiefs Organization [SCO], 2002) First Nations people argue that they have not experienced the same level of health services as their fellow non-Aboriginal Canadians. Provinces have primary responsibility for health care delivery but the federal government has a responsibility in publicly funded health care, including the protection and promotion of health. (Health Canada, 2004) First Nations argue that the federal government has not fulfilled responsibilities in the health care system. Many First Nations put forth the argument that the issue of health is not just one of policy; it is a treaty and an inherent right. For example, Manitoba First Nations cited in Wabung (1971) their position “that the Medicine Chest of treaty-signing days, interpreted in the light of today’s context, applies to all Indians of Canada to mean all medical services, medicare, public health services, medicines, hospital services, laboratory services, eye care, dental care, and medical appliances.”(1971, p. 74.) This position was repeated to the Royal Commission on Aboriginal People [RCAP] and to the Romanow Commission by the Assembly of First Nations and other First Nations organizations such the Alberta First Nations, Assembly of Manitoba Chiefs, and by Southern Chiefs Organization of Manitoba to name a few. (Alberta First Nations, 2002, AFN, 2002, AMC, 2002, DOTC, 2002, SCO, 2002, RCAP 1996)

The release of the Commission on the Future of Health Care in Canada's Final Report in November 2002 coincided with Saskatchewan's 40th anniversary of medicare. (Romanow, 2002, p. xxi). For First Nations people, those 40 years of medicare translate into a reminder that Canada has not adequately met the needs of First Nations' health care. In Wahbung (1971), First Nations identified issues such as accessibility to health services, rights to health care, and transportation that needed to be address by the federal government. These issues are consistent with what First Nations people identified to the Romanow Commission. (Mackinnon, 2005, Romanow, 2002) Canada purports that the federal government is responsible for providing quality health services to First Nations and Inuit along with other groups. (Romanow, 2002, p.3) Many First Nations argue that the federal government has not fulfilled its responsibility to provide health services adequately to First Nations. (Romanow, 2002, RCAP, 1996; Wahbung, 1971,)

ii. The Commission on the Future of Health Care in Canada

In April 2001, the Government of Canada established the Commission on the Future of Health Care in Canada. The Romanow Commission's mandate was to review the health care system, engage in a national dialogue with Canadians on the future of medicare and make recommendations to improve the health care system's quality and sustainability. Further, the Commission's mandate was to recommend policies and ways to make sure of the long-term sustainability of a universally accessible, publicly funded health system. (Romanow, 2002, p. xv)

The Romanow Commission carried out its mandate in two stages. The first stage was fact-finding [June 2001 to Dec 2001]. At the end of this stage, the Romanow Commission produced an interim report, which was a synthesis of the Commission's

findings. During the first stage, Canadian organizations have participated by submitting written submissions to the Romanow Commission. The second stage of the commission's work was to dialogue with the Canadian public and interested stakeholders throughout the country. During the second stage, there was a consultation period where public hearings were held [March 4, 2002 to May 31, 2002]. Aboriginal organizations participated in both stages of the Romanow Commission, the fact-finding phase and the consultation phase.

iii. Aboriginal/First Nations Participation in the Romanow Commission

Aboriginal/First Nations organizations throughout Canada participated in the Romanow Commission in an effort to create awareness about their experiences with the health care system and to influence change in Aboriginal health.

During the first stage of the Romanow Commission, ten (10) Aboriginal organizations participated by submitting written submissions. In the second stage, thirty-two (32) Aboriginal organizations participated in the public hearings held across the country. The Romanow Commission worked with the National Aboriginal Health Organization (NAHO 2002) and hosted a national forum [June 26, 2002, Aylmer, Quebec] on Aboriginal health issues. First Nations, Métis, Inuit, urban Aboriginal people and communities came together to share their successes, challenges, and views on the future of health care. (Romanow, 2002, p. 211) The Romanow Commission tabled a final report with forty-seven (47) recommendations regarding the health care system and its direction. There were two (2) recommendations regarding a new approach to Aboriginal Health, which were as follows:

“Recommendation 42 – Current funding for Aboriginal health services provided by federal, provincial and territorial governments and Aboriginal organizations should be pooled into single consolidated budgets in each province and territory to be used to integrate Aboriginal health care services, improve access, and provide adequate, stable and predictable funding.

Recommendation 43 – The consolidated budgets should be used to fund new Aboriginal Health Partnerships that would be responsible for developing policies, providing services and improving the health of Aboriginal peoples. These partnerships could take many forms and should reflect the needs, characteristics, and circumstances of the population served.” (Romanow, 2002, p.253)

Some examples of the Aboriginal Health Partnerships as suggested in the Romanow Commission’s Final Report included; a regional partnership model targeting all individuals who want to benefit from integrated and culturally appropriate health services; or a community initiative model for individuals or communities, and a local partnership model where health care providers and others are concerned with services for urban Aboriginal people. (Romanow, 2002, p.229)

iv. First Nations Health Status in Canada

The First Nations and Inuit Regional Health Survey [FNIRHS], (1999) was undertaken because First Nations and Inuit people had been left out of the three major national surveys related to health; the National Population Health Survey, the National Longitudinal Survey of Children and Youth, and the Survey of Income and Labour Dynamics. (FNIRHS, p. 185) The timing of the FNIRHS (1999) is significant as First Nations and Inuit people had a growing concern that the present health system was not

meeting their needs, issues related to limited resources affecting program priorities and the concerns regarding health transfer agreements with the Federal governments. (p. 185)

The FNIRHS survey asked First Nations and Inuit if they believe that they had the same level of health service as the general population of Canada and 47 percent of respondents reported services were not at the same level as the rest of Canada. (1999, p. 193). First Nations and Inuit want a different health care system than the one they currently have. (Romanow, 2002, FNIRHS, 1999)

First Nations live in a country where Canada's federal health department wants Canadians to be the healthiest in the world. However, the First Nations Regional Longitudinal Health Survey hereafter, (RHS) in 2002-03 identified significant gaps regarding the living conditions and health of First Nations compared to Canadians in general. (FNIRHS, 2003, P.11) Some health issues faced by First Nations that RHS (2003) reported are that their diabetes rates are three times the Canadian average, residential schools have had negative impacts on First Nations health and well being, obesity rates in First Nations are twice as high as for Canadians, smoking rates are more than double the Canadian average, and that water is considered unsafe in many First Nations homes. First Nations were more likely to be living in crowded homes in 2002 than Canadians in 1991; and mold and mildew affected a large number of First Nations homes. (RHS, 2003, p. 11)

Health Canada (2003) reported that Aboriginal health status, which includes First Nations, has improved in some areas such as life expectancy and the reduction of infant mortality. However, this improvement in health status is not as good as that of non-Aboriginal Canadians. Health Canada stated that Aboriginal people face higher rates of

chronic disease, such as diabetes, which affects First Nations people at a rate of three to five times higher than the general Canadian population. Infectious diseases, such as tuberculosis where Aboriginal Canadians have rate ten times higher than for other Canadians. There is a gap in life expectancy of Aboriginal people compared to the non-Aboriginal population. On average, First Nations men live seven years less than other Canadian men, and First Nations women, five years less than other Canadian women. Higher rates of suicide, especially among Aboriginal youth with a suicide rate for First Nations youth that is five to six times higher than the national average and for Inuit youth eleven times higher. The living conditions and health of First Nations people continues to be dismal. (Health Canada, 2003; NAHO, 2002; Young, 1988)

Martens, Sanderson, and Jebamani (2005) noted that First Nations Canadians experience greater mortality and morbidity rates than the general Canadian population and should therefore access services at a higher rate. However, 18 % of First Nations Manitobans report needing care and not receiving it, only 13% reported adequate availability of primary care and 6% reported adequate availability of specialists. The inadequate availability of health professionals is just one example of a barrier faced by First Nations when they access health care services. (Martens, et. al. 2005, p. S44). First Nations continued to identify to the Commission on the Future of Health Care (2002) the ongoing barriers they face in the health care system.

This researcher remains optimistic that First Nations will continue to advocate for changes to the health care system to address the First Nation health status gap. As a First Nations Canadian, I continue to remain confident that First Nations have their own

solutions to meet their health care needs at an individual level and at community levels services.

III. METHODOLOGY

This research explored what First Nations people told the Romanow Commission about what was needed from Canada's Health Care System. It reviewed all English Aboriginal/First Nations' submissions to the Romanow Commission. This research used content analysis to explore the ideas presented in documents. By conducting a content analysis, inferences were drawn from the research data, which will be discussed later in this section.

Further, the researcher used a conceptual framework – the Aboriginal Life Promotions Framework” [ALPF] developed by Judith Bartlett. (Bartlett, 2004) as a sensitizing framework, which allowed the researcher to organize the data from a cultural perspective. The ALPF offered a sensitizing framework for the researcher that provided a beginning guide and starting point for my research. Using ALPF offered a way to organize data in a holistic manner and to make some decisions as to what to extract. (Patton, 2002, p.278) This researcher created data collection tools, which used the ALPF sixteen elements of human existence to review the recommendations from that reference point; a holistic perspective.

This research undertook a qualitative approach that allowed flexibility when trying to understand complex issues. Morse and Richards (2000) outlined various situations when qualitative approaches might be the best or the only way to address some research questions. My purpose was to understand what First Nations wanted from the health care system, to discover themes and to provide an analysis. (pp. 27 & 28) York (1997) indicated, “Qualitative research methods employ a flexible means of observation.” and “qualitative measurement is more suitable to the development of theory and the

subjective description of social phenomena”. (p. 261) Further, it is reported, “Qualitative measurement is also more suitable if the purpose of the study is the description of the subjective meaning of human processes or events as opposed to the precise description of them.” (p. 261). The literature notes that another researcher cannot duplicate this type of research as another researcher may ask the same question but may use a different analytic technique or different research method. (Morse & Richards, 2002)

i. Cultural Context

This research was based on the premise that changes to the health care system for First Nations must come from First Nations people. It is with this shared belief that this researcher supports the notion of a holistic approach to health care advocated by First Nations. (AMC, 2002, DOTC, 2002, Romanow, 2002) I have worked in various First Nation organizations³, which have embodied holistic approaches that paid attention to the physical, mental, spiritual and emotional aspects related to policy/program development and service delivery by the organizations.

As First Nations, we want control regarding the future direction of the health care system. First Nations have stated that they want a different system to meet their health needs. (Romanow, 2002; DOTC, 2002, AMC, 2002) This thesis presents research from a First Nations perspective regarding First Nations health issues and advocates a more holistic approach that would present a paradigm shift in policy direction and policy making regarding health care. This shift involves First Nations’ people making decisions in health care funding, program design, program service delivery, and First Nations’ government health structures.

³ In Manitoba, I have worked at the following First Nation organizations, Awasis Agency of Northern Manitoba, Cree Nation Child and Family Caring Agency, Assembly of Manitoba Chiefs and West Region Child and Family Services, Inc.