

# ENVISIONING THE FUTURE OF ABORIGINAL HEALTH UNDER THE HEALTH TRANSFER PROCESS

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## Introduction

The Canadian government, and many Aboriginal communities, are committed to formally transferring varying aspects of governance responsibilities from federal hands to Aboriginal ones.<sup>1</sup> These transfers take various forms, from creating Aboriginal political bodies with broad sets of governance powers, as was the case with the Nisga'a Treaty of 2000, to more partial transfers of specific powers or responsibilities, or types of responsibilities. One core transfer area is public health programming,<sup>2</sup> for which there are specific and highly developed initiatives dating back to around 1989.<sup>3</sup> Although it

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1 See e.g. Canada, Department of Indian Affairs and Northern Development, *Federal Policy Guide, Aboriginal Self-Government: The Government of Canada's Approach to the Implementation of the Inherent Right and Negotiation of Aboriginal Self-Government* (Ottawa: Minister of Indian Affairs and Northern Development, 1995).

2 James B. Waldram, D. Ann Herring & T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995) at 262 [Waldram *et al.*]

3 Health Canada, *Ten Years of Health Transfer First Nation and Inuit Control* (Ottawa, Ont.: Health Canada, 1999), online: Health Canada, First Nations, Inuit and Aboriginal Health <[http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/\\_agree-accord/10\\_years\\_ans\\_trans/2\\_intro-eng.php#Introduction](http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/10_years_ans_trans/2_intro-eng.php#Introduction)>.

is expected that these initiatives will, overall, have very positive effects for improving the health of Aboriginal Canadians,<sup>4</sup> there are many difficulties which are likely to emerge or be perpetuated under these transfers. There has been limited analysis of these difficulties to date.

This paper first briefly describes the history of health transfer initiatives, and the policies which currently shape transfer agreements. After establishing this general platform, the paper then takes up the challenge of querying whether improvements to health status actually follow these forms of transferred control. The point of asking this question, as James Waldram, Ann Herring and Kue Young suggest, is not to undermine the efforts of Aboriginal communities to ameliorate their often poor living conditions,<sup>5</sup> but to generate an analysis of how law, policy, and jurisdictional assignment impede or facilitate the success of such initiatives, and so gather insight into how to make improvement more likely. This paper considers some existing gaps or problems in Aboriginal public health which are likely to be perpetuated despite the transfer of control over some aspects of these problems, as well as some gaps related to health which may emerge in transfer communities. It then turns to identifying some aspects of health which are likely to improve in the coming years with increased Aboriginal control. The analysis in this paper is obviously a selective one: there are many other "gaps" which could have been included. As such, it is intended to contribute to the initiation of a broader conversation about the future of Aboriginal health under the health transfer process.

## 1. Health Transfer Agreements

The federal government has long taken responsibility for providing health services to some portions of the Aboriginal population.<sup>6</sup> The Aboriginal pop-

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4 See Laurel Lemchuk-Favel & Richard Jock, "Aboriginal Health Systems in Canada: Nine Case Studies" (2004) 1:1 *Journal of Aboriginal Health* 28 at 28-30, 33 [Lemchuck-Favel & Jock]; Assembly of First Nations, *First Nations Public Health: A Framework for Improving the Health of Our People and Our Communities* (November 2006) at 24, online: Assembly of First Nations <<http://www.afn.ca/cmslib/general/FNPB-IH.pdf>> [Assembly of First Nations, *First Nations Public Health*].

5 Waldram *et al.*, *supra* note 2 at 257.

6 For an overview of the history of federal health initiatives, see *ibid*; Josée G. Lavoie, "The Value and Challenges of Separate Services: First Nation in Canada" in Judith Healy & Martin McKee, eds., *Accessing Health Care: Responding to Diver-*

ulation served by the federal government has changed somewhat over time, but has come to be almost exclusively limited to Aboriginal people who are registered as “Indians” under the *Indian Act*<sup>7</sup> (aka have “status”) and Inuit.<sup>8</sup> Reflecting this population, the federal government has located most of its Aboriginal health bureaucracy within a division of Health Canada called the “First Nations & Inuit Health Branch” (FNIHB). Although a specific target of federal attention, the health status of First Nations and Inuit people, like the health of other Aboriginal Canadians, has consistently been found to be substandard when compared to non-Aboriginal Canadians.<sup>9</sup> A key initiative to address this situation commenced in September of 1979, when the Federal Government’s Indian Health Policy was tabled.<sup>10</sup> This two page docu-

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*sity* (London: Oxford University Press, 2003) 325 at 326-7, 329 [Lavoie, “Value and Challenges”]. The source and scope of this responsibility is contentious, as some Aboriginal groups take the position that the federal government is obliged, as a fiduciary or pursuant to treaty promises, to provide all Aboriginal people, or at least those whose ancestors adhered to certain treaties, with health care services. See Constance MacIntosh, “Jurisdictional Roulette: Constitutional and Structural Barriers to Aboriginal Access to Health” in Colleen M. Flood, ed., *Just Medicare: What’s In, What’s Out, How We Decide* (Toronto: University of Toronto Press, 2006) 193 at 198-203 [MacIntosh, “Jurisdictional Roulette”]. The federal government, on the other hand, considers service provision to be a matter of public policy, and so provided at its discretion. See Assembly of First Nations, *First Nations Public Health*, *supra* note 4 at 22; Waldram *et al.*, *supra* note 2 at 238-9, 242-3; Martha Jackman, “Constitutional Jurisdiction Over Health in Canada (2000) 8 Health L.J. 95 at paras. 19-23; Kristen M. Jacklin & Wayne Warry, “The Indian Health Transfer Policy in Canada: Toward Self-Determination or Cost Containment” in Arachu Castro & Merrill Singer, eds., *Unhealthy Health Policy: A Critical Anthropological Examination* (Walnut Creek, Cal.: Alta Mira Press, 2004) 215 at 216 [Jacklin & Warry]. The relative strength of these positions, and the question of whether entering health transfer agreements would impact upon the viability of these claims, are outstanding issues and not within scope of this paper.

7 *Indian Act*, R.S.C. 1985, c. I-5, s. 6.

8 Lavoie, “Value and Challenges”, *supra* note 6 at 328.

9 See e.g. Jacklin & Warry, *supra* note 6 at 215.

10 Health Canada, *Indian Health Policy 1979* (Canada: Health Canada Medical Services Branch 1979) [Health Canada 1979]. Indian Health Policy 1979, online: Health Canada <[http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli\\_1979-eng.php](http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php)>.

ment identified three pillars for achieving the goal of increasing “the level of health in Indian communities, generated and maintained by the Indian communities themselves.” It identified the most important pillar as socio-economic, cultural and spiritual development to address poverty and apathy within communities. The second pillar was described as the relationship between Aboriginal people and the Federal Government, “in which the federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations.”<sup>11</sup> The third pillar would be the federal government’s commitment to “maintaining an active role in the Canadian health system as it affects Indians.”<sup>12</sup>

Notably, this policy document wrote of “Indian communities,” not reserves, and so suggested a recognition of community membership which extended beyond reserve residents. It also foregrounded the need to address socio-economic development, and support Aboriginal community control, if health was to improve. However, over the next decade, implementation models and government discussion documents adopted a focus upon a more limited population, on-reserve status Indians. The broader context of addressing health determinants and general capacity building was side-lined by a focus upon one element, transferring control over the delivery of public health services.<sup>13</sup>

In 1989, ten years after the Indian Health Policy was tabled, the Health Transfer Policy<sup>14</sup> was announced by the federal government. It was described as “the best way to deal with the [health] inequalities existing between Aboriginal Peoples and the rest of Canada.”<sup>15</sup> The initiative focused upon transferring federal resources to south-of-60 First Nations and Inuit to design and manage some of the community-based health programs which were, at

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11 *Ibid.*

12 *Ibid.*

13 Dr. Josée G. Lavoie *et al.*, *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report: Volume 2, Report* (Winnipeg, Man.: Centre for Aboriginal Health Research, 2005) at 38 [Lavoie *et al.*, *Final Report*].

14 For a detailed discussion of the development and evolution of the Health Transfer Policy, see *ibid.* at 36-46. See also Waldram *et al.*, *supra* note 2 at 234.

15 Josée G. Lavoie, “Governed by Contracts: The Development of Indigenous Primary Health Services in Canada, Australia and New Zealand” (2004) 1:1 *Journal of Aboriginal Health* 6 at 12.

that time, planned, controlled and delivered by FNIHB.<sup>16</sup> Programs which are currently available for inclusion within the transfer envelope include nursing, community health representatives, Health Coordinator, National Native Alcohol and Drug Abuse Program, Prenatal Nutrition, and Building Healthy Communities.<sup>17</sup> Initially, all benefits provided under the federal Non-Insured Health Benefits program, which funds certain health benefits not covered by provincial health care programs (dental care, medical transportation, medication and vision care) were excluded from transfer. However, in 1998, trials were initiated for making the programming for drugs, dental services, and vision care as well as mental health programming available for transfer to communities.<sup>18</sup> Physician services, and hospital services are necessarily outside of these envelopes because they fall within provincial jurisdiction.<sup>19</sup>

At the moment, there are three general types of arrangements, called “contribution agreements,” for transferring health programming. Each type of arrangement has a different level of flexibility and control post-transfer. A Consolidated Contribution Agreement – General [“General Agreement”] is an agreement to deliver a limited parcel of specific programs and usually has a one year term. Under a General Agreement funding is assigned to each program. The Aboriginal community has no authority to re-direct funding in response to changing needs, rather they must follow the blueprint as set out in the contract.<sup>20</sup> The second type of agreement, Consolidated Contribution Agreement-Transfer/Targeted [“Transfer/Targeted Agreement”], allows First Nations more discretionary control, and has terms of three to five years. First Nations who wish to enter into Transfer/Targeted Agreements must agree to deliver three specific programs: Communicable Disease Control, Environmental/Occupational Health and Safety, and Treatment Ser-

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16 John O’Neil & James Blanchard, *Consideration for the Development of Public Health Surveillance in First Nations Communities* (Winnipeg, Man.: Centre for Aboriginal Health Research, 2001) at 26 [O’Neill & Blanchard].

17 Lavoie *et al.*, *Final Report*, *supra* note 13 at 5-7.

18 O’Neill & Blanchard, *supra* note 16 at 27.

19 *Eldridge v British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 at 677, 151 D.L.R. (4<sup>th</sup>) 577 [*Eldridge* cited to S.C.R.].

20 Health Canada, First Nations, Inuit and Aboriginal Health, “Contribution Agreements”, online: Health Canada <[http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/index\\_e.html](http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/index_e.html)> [Health Canada, “Contribution Agreements”].

vices,<sup>21</sup> but are otherwise able to select from a suite of programs to plan and deliver. Funds allocated to the mandatory programs must be spent according to a plan developed prior to the transfer being approved. However, all other programming is open to the Aboriginal community unilaterally making amendments (e.g. re-allocating funds between programs) after the transfer has occurred.<sup>22</sup> The third type of agreement is the Consolidated Contribution Agreement – Integrated/Targeted [“Integrated Agreement”]. It involves the First Nation taking responsibility for developing a broader health management structure, but has limited flexibility to adjust programming and reallocate resources.<sup>23</sup>

In the case of all three types of transfer agreements, the agreement includes a non-enrichment clause, which means that funding to deliver programming is calculated according to delivery costs per on-reserve status Indian at the time of the transfer, and increased only by standardized cost-indexing. Funding increases to specific agreements are not normally permitted, regardless of changes to actual costs or in the size of the population over the course of the agreement, nor are the funding figures up for re-negotiation when the agreement is renewed.<sup>24</sup> As discussed below, this policy leaves the quality of programming quite vulnerable as real costs change.

The Health Transfer Policy has been viewed with suspicion by some academics and Aboriginal communities.<sup>25</sup> Their concerns focus primarily upon the impact of excluding off-reserve community members from the funding formulas, the affect of the non-enrichment clause, and “the affect the agreements may have on treaty rights and fiduciary responsibility of govern-

21 Health Canada, Business Planning and Management Directorate, First Nations and Inuit Health Branch, *Transfer of Health Programs to First Nations and Inuit Communities: Handbook 2 – The Health Services Transfer* (Ottawa, Ont.: March 1999, Revised March 2004) at 9 [Health Canada, *Health Services Transfer*].

22 Health Canada, “Contribution Agreements”, *supra* note 20.

23 *Ibid.*

24 Lemchuk-Favel & Jock, *supra* note 4 at 36-7.

25 See e.g. Jacklin & Warry, *supra* note 6; Dara Culhane Speck, “The Indian Health Transfer Policy: A Step in the Right Direction or Revenge of the Hidden Agenda?” (1989) 5:1 *Native Studies Review* 187. Some Aboriginal communities have refused to engage in the transfer process, due to concerns that it would affect claimed treaty rights to health services. This concern appears to be particularly strong in Alberta, where only 3 communities have signed transfer agreements. (See Assembly of First Nations, *First Nations Public Health*, *supra* note 4 at 25).

ment.”<sup>26</sup> Nonetheless, these options for greater Aboriginal participation and control over aspects of health have been widely pursued. By 2001, 41% of eligible communities had entered into some form of transfer agreement.<sup>27</sup> By March of 2008, the number had risen to 83% of eligible First Nations communities. Of these communities, approximately 1/3 had entered into a General Agreement and 2/3 had entered into a Transfer/Targeted Agreement.<sup>28</sup>

This paper turns now to considering what gaps in health are likely to persist despite control over some aspect of a health issue being transferred, what gaps are likely to emerge in transfer communities, and what gaps are likely to close in the coming years.

## **2. Existing Gaps which are likely to be perpetuated or worsen under transfer**

### Introduction

As noted above, the health transfer process, as an expression of the Federal Indian Policy, is intended to ameliorate the significant disparities, or gaps, between the health status of Aboriginal people and non-Aboriginal people in Canada by a strategy of community controlled planning and delivery. However, there are many existing health-related gaps which are particularly vulnerable to persisting, or worsening, despite control over aspects of those health issues having being transferred. These issues range from the most rudimentary problems of recruiting and retaining health care professionals, to complex multi-jurisdictional problems such as providing safe drinking water. With these sorts of hurdles, changing who is planning and delivering programs, from FNIHB to a First Nation, is unlikely to engender improvements, either because the problem is one which plagues the health care system generally, or because the problem requires a comprehensive response which is beyond the authority or resources of most First Nations.

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26 O'Neill & Blanchard, *supra* note 16 at 19.

27 Lavoie *et al.*, *Final Report*, *supra* note 13 at 15.

28 Health Canada, First Nations, Inuit and Aboriginal Health, "Transfer Status as of March 2008", online: Health Canada <[http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/trans\\_rpt\\_stats\\_e.html](http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/trans_rpt_stats_e.html)>.

### Gaps associated with Retention and Recruitment

With transfer comes community responsibility for issues typically associated with provincial health care delivery, such as “merging program administrations and creation of more efficient management structures; [developing] effective governance models, recruitment and retention strategies; integration, mergers and other collaborative relationships with neighboring First Nations; and primary care reform.”<sup>29</sup> A pivotal issue then, and one which is faced by provinces generally, is the challenge of recruiting and retaining nursing staff.<sup>30</sup> Access to health care professionals has long been a problem for Aboriginal communities, and this problem is likely to persist, if not worsen, under transfer agreements. This vulnerability is in part a result of transfer agreements always including “non-enrichment clauses” which results in funding being based on expenditures the year before the community initially entered into a transfer agreement. The result has been that not only are First Nations “locked into a level of funding based on historical expenditure,” but also that First Nations have different per capita funding depending upon the year they entered into their agreement.<sup>31</sup> The differences are staggering – Lavoie, Forget and O’Neil reported in 2007 that per capita funding for health centres in medium sized communities ranged from \$430 to \$1,418. Their analysis determined that the differences between these figures are not proportional to program responsibilities, nor to external factors such as remoteness – instead they reflect the face of government spending the year the community entered transfer, with the general trend being that those who entered early have proportionately less funding.<sup>32</sup>

Given the funding lock-in, even those First Nations on the higher end of the funding scale may find themselves unable to compete with the increases in salary, or other recruitment incentives, which are offered to health care professionals to work as federally or provincially funded em-

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29 Lemchuk-Favel & Jock, *supra* note 4 at 40.

30 *Ibid.* at 34; Dr. Josée G. Lavoie *et al.*, *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report: Volume 1, Executive Summary* (Winnipeg: Centre for Aboriginal Health Research, May 2005) at 6 [Lavoie *et al.*, *Executive Summary*].

31 Josée G. Lavoie, Evelyn Forget & John D. O’Neil, “Why Equity in Financing First Nations On-Reserve Health Services Matters: Findings from the 2005 National Evaluation of the Health Transfer Policy” (2007) 2:4 *Healthcare Policy* 79 at 93.

32 *Ibid.* at 92.

ployees.<sup>33</sup> A 2005 evaluation of the health transfer programme described recruitment and staffing problems in many communities as “becoming insurmountable.”<sup>34</sup> Community options are either to find more money elsewhere, which is not possible in some communities due to general impoverishment, divert funding from other programs, or else relinquish control over that component of health transfer. This last option has an ironic character: with federal control comes federal pay scales, and so a likely lessening of the staffing problem, but at the cost of abandoning local control – the very element which is expected to engender improvements. (Obviously this third option does not obviate the general problem with nursing shortages, or the difficulty in recruiting nurses to work in communities where they may have little professional support and experience isolation. It merely addresses the inability of First Nations to compete with federal and provincial pay scales and incentives.)

### Gaps associated with existing administrative and jurisdictional arrangements

It is reasonable to assume that some communities will have or find the resources to mitigate against the staffing issue, or develop some other creative strategy. A determination to succeed will, however, be unlikely to enable transferred First Nations to address health issues which are embedded within jurisdictional tangles. To shift from the pan-Canadian problem of staffing to one which is more specific to First Nations, this paper turns now to the issue of safe drinking water, as an example of where health transfer pursuant to a Transfer/Targeted Agreement is likely to do little more than enable local administration of a persistent and complex public health problem, instead of resolving it. As described above, any community which wishes to engage in this more flexible form of health transfer is required to agree to deliver three specific programs in addition to those programs which it has selected from the options list. These mandatory programs include Environmental/Occupational Health and Safety.<sup>35</sup> The Environmental Health Program must include inspection activities for water supplies and sewage disposal.<sup>36</sup> This means that if a community seeks to enter into a Transfer/Targeted Agreement for

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33 Lavoie *et al.*, *Final Report*, *supra* note 13 at 90.

34 *Ibid.*

35 Health Canada, *Health Services Transfer*, *supra* note 21 at 9.

36 *Ibid.* at 10-11.

health transfer, it must take responsibility for monitoring the drinking water and sewage water infrastructure. As a result, an aspect of control over a persistent public health related problem is transferred. Is such a transfer likely to improve water quality and so public health on reserves, or just perpetuate an unsatisfactory status quo? Aboriginal organizations have sought, since at least 1980, to require "that unacceptable environmental conditions, including water and sanitation, be brought up to a level of parity" with Canadian standards.<sup>37</sup> Thus far, despite a series of well-funded federal initiatives and policies,<sup>38</sup> the Commissioner of the Environment and Sustainable Development has concluded that "[w]hen it comes to the safety of drinking water, residents of First Nations communities do not benefit from a level of protection comparable with that of people living off reserves."<sup>39</sup> Protection is lacking in part because water facilities have been consistently poorly maintained. This problem in turn is partially linked to staffing problems – as of 2003, only 8% of operators who run and maintain the facilities were certified, and so would be permitted by provincial regulation to work in a provincial facility. There are no legal standards regulating the training and qualifications of operators on reserves. Although the First Nations Water Management Strategy was expected to ensure that all on-reserve opera-

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37 As reported in the Royal Commission on Aboriginal Peoples, Centre for Policy and Program Assessment, School of Public Administration, Carleton University, *Public Policy and Aboriginal Peoples 1965-1992, Vol. 2: Summaries of Reports by Federal Bodies and Aboriginal Organizations* (Ottawa, Ont.: Royal Commission on Aboriginal Peoples, 1994) at 226-7.

38 For example, the Department of Indian and Northern Affairs committed to a ten year plan to address water quality in 1991 (Office of the Auditor General of Canada, *1995 November Report of the Auditor General of Canada* (Ottawa, Ont.: Office of the Auditor General, 1995) at 23.21); a nine year plan in 1994 (Canada, Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples, Vol. 3, Gathering Strength* (Ottawa, Ont.: Royal Commission on Aboriginal Peoples, 1996) at 380-81); and a five year plan in 2003 (Treasury Board of Canada Secretariat, *First Nations Water Management Strategy: Plans, Spending and Results for 2003/4*, online: Treasury Board of Canada Secretariat <[http://www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/dep-min/inac-ainc/fnwms-sgepn/2003-2004\\_e.asp](http://www.tbs-sct.gc.ca/rma/eppi-ibdrp/hrdb-rhbd/dep-min/inac-ainc/fnwms-sgepn/2003-2004_e.asp)>).

39 Canada, Commissioner of Environmental and Sustainable Development, *2005 September Report of the Commissioner of the Environment and Sustainable Development* (Ottawa, Ont.: Office of the Auditor General of Canada, 2005) at para. 5.76 [Commissioner of the Environment and Sustainable Development].

tors were certified by 2008, this seems unlikely, as by March of 2007 only 37.4% of the operators were certified.<sup>40</sup> The problem of poor maintenance is also linked to funding. Much like public health programming, the federal government has been devolving administrative responsibility for running capital facilities like water treatment plants to First Nations. Although responsibility for maintaining the infrastructure is transferred, funding is limited to 80% of the estimated operation and maintenance costs, and the Commissioner of the Environment has found that “INAC ignores whether First Nations have other resources to meet this requirement [to fund 20%] and has no means to enforce it.”<sup>41</sup>

Coupled with these on-the-ground difficulties of funding and the legislative lacuna regarding operator standards, is the broader jurisdictional and legislative context in which water quality is monitored and regulated. There is no regulatory bundle which legislates water quality standards and creates a clear line of accountability for addressing problems on reserves. This legislative gap leaves all potentially liable actors, including the federal government and managing Band Councils, potentially off the hook unless or until a lawsuit is launched. Nor is there a legislated link to bring the extra-jurisdictional drinking water interests of First Nation communities<sup>42</sup> into provincial environmental decision-making, thus leaving their inclusion as a matter of good will or good faith, or potentially only through after-the-fact litigation.<sup>43</sup>

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40 Indian and Northern Affairs Canada, *Plan of Action for Drinking Water in First Nations Communities: Progress Report – March 22, 2007* (Ottawa, Ont.: Indian and Northern Affairs Canada, 2007) at 5.

41 Commissioner of the Environment and Sustainable Development, *supra* note 39 at para. 5.59.

42 It is essential to distinguish here between Aboriginal rights which are “recognized and affirmed” under s.35(1) of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 and so cannot usually be infringed by a state actor without consultation to enable the accommodation of the protected right, and interests such as having clean water which are unlikely to meet the threshold for s.35(1) protection. This protection is only triggered where the claimed “practice” or “tradition” is shown to be “integral to the distinctive culture” of the relevant Aboriginal people. See *R. v. Sappier; R v. Gray*, 2006 SCC 54, [2006] 2 S.C.R. 686 at para. 20.

43 See Constance MacIntosh, “Testing the Waters: Jurisdictional and Policy Aspects of the Continuing Failure to Remedy Drinking Water Quality on First Nation Reserves” (2008) 39.1 *Ottawa L. Rev.* 63 [MacIntosh, “Testing the Waters”].

As a result, quality and practices reflect shifting federal and provincial protocols, which may or may not prove adequate, but which do not give reserve residents a lawful chain of accountability.

The point in describing these inadequacies is not to disparage attempts which the federal government, and Aboriginal communities, have been making to improve water quality and safety. The point, rather, is to illustrate that the difficulties which undermine efforts to improve water quality cannot be solved by a single actor. The mandatory reassignment of who is responsible for monitoring the situation in this given context is unlikely to result in substantive changes to the situation or otherwise meet the primary goal of the health transfer process. To ameliorate key sources of the disparities between the health status of Aboriginal and non-Aboriginal Canadians, of which access to safe drinking water is one, comprehensive strategies supported by both federal and provincial legislation, and endorsed by aboriginal communities, are necessary.

#### Gaps associated with public health surveillance<sup>44</sup>

Under health transfer agreements, public health surveillance within Aboriginal communities is also likely to become more difficult, at least in the short term. However, as discussed in the final section of this paper, there is room for health surveillance to ultimately improve in conjunction with Aboriginal communities increasingly taking control of health data about their members, and also coming to form more direct relationships with provincial health care authorities.

Public health surveillance is the process of systematically collecting, analyzing, and interpreting outcome-specific data which is used for planning, implementing and evaluating public health practices.<sup>45</sup> Rather than a general survey of health status, surveillance is directed to understanding, monitoring, and responding to specific health issues within defined populations.<sup>46</sup> As observed by the SARS Commission<sup>47</sup>, and information system

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44 This section has benefited from generous guidance and comments from Dr. Elaine Gibson.

45 O'Neill & Blanchard, *supra* note 16 at 11.

46 *Ibid.*

47 Hon. Mr. Justice Archie Campbell, Commissioner, *The SARS Commission Interim Report: SARS and Public Health in Ontario* (April 15, 2004), online: The SARS Commission <[http://www.sarscommission.ca/report/Interim\\_Report.pdf](http://www.sarscommission.ca/report/Interim_Report.pdf)>; Hon

scholars such as Elaine Gibson,<sup>48</sup> the legislation and policy which supports public health surveillance practices in Canada have been found to be in need of considerable improvement, especially in terms of usefully organizing and sharing information.<sup>49</sup> Various initiatives have been recently struck to try to address these failings.<sup>50</sup>

Although Gibson and the SARS Commission have written about surveillance practices generally, their comments are equally applicable to the health surveillance system for First Nation communities. Unique reasons for its weaknesses relate to jurisdictional disconnections, database limitations, and disputes regarding who has the right to control what data is collected and access to that data. This paper only addresses the jurisdictional problems here, as the other two issues also arise as matters of general data collection and so are addressed in the final section of this paper.

The jurisdictional disconnect reflects a distinction between who receives public health surveillance information and who provides public health programming. Although jurisdiction over public health arguably straddles the division of powers,<sup>51</sup> provinces have asserted primary authority for the protection of local public health under the *Constitution Act, 1867*,<sup>52</sup> and under this authority have enacted the core public health surveillance legislation in Canada. (It is worth noting that this legislative situation may change, as the federal government appears to have provincial support for its initiative

Mr. Justice Archie Campbell, Commissioner, *Spring of Fear : Volume 1: The SARS Commission: Executive Summary* (December 2006), online: The SARS Commission <<http://www.sarscommission.ca/report/v1-pdf/Volume1.pdf>>.

48 Elaine Gibson, "Public Health Information Privacy and Confidentiality" in Tracey M. Bailey, Timothy Caulfield, & Nola M. Ries, eds., *Public Health Law and Policy in Canada* (Toronto, Ont.: LexisNexis Butterworths, 2005) 89 at 123-8 [Gibson].

49 *Ibid.* at 127.

50 See, for example, the initiatives listed on the Canadian Public Health Agency's webpage, at <[http://www.phac-aspc.gc.ca/about\\_apropos/index.html](http://www.phac-aspc.gc.ca/about_apropos/index.html)>.

51 See e.g. the concurring decision of Estey J. in *Schneider v The Queen*, [1982] 2 S.C.R. 112 at 141-2, 103 D.L.R. (3d) 417 [*Schneider* cited to S.C.R.] and Lamer C.J. in *R v Swain*, [1991] 1 S.C.R. 933 at 1004, [1991] S.C.J. No. 32 [*Swain* cited to S.C.R.]. A review of the scholarly debate over jurisdictional assignment can be found in Sujit Choudhry, "Recasting Social Canada: A Reconsideration of Federal Jurisdiction over Social Policy" (2002) 52 U.T.L.J. 163 at fn. 71.

52 *Constitution Act, 1867 (UK)*, 30 & 31 Vict., c.3, s.92(7), (13),(16), reprinted in R.S.C. 1985, App. II, No.5.

to play a central role in public health surveillance with the creation of the Canadian Public Health Agency.<sup>53</sup>) One focus of existing provincial surveillance legislation is communicable diseases, as well as some selected non-communicable diseases such as cancer, and to this end provincial regulations typically require health care providers to inform provincial health authorities if a disease which the province has listed on a schedule is encountered,<sup>54</sup> a so-called “notifiable disease.” So, when a person who lives in a First Nation community, or who is an off-reserve community member, is diagnosed with a notifiable disease, the health care provider reports this information to the province. However, as “Indians and Land Reserved to the Indians” was assigned pursuant to the division of powers to the federal government, responsibility for public health on reserves is within federal jurisdiction.<sup>55</sup> As a result there is a jurisdictional disconnect between who, by law, has created a mechanism for receiving information, and who, pursuant to constitutional arrangements, is responsible for programming, creating a time lag if not a data barrier. As privacy and confidentiality interests arise when health surveillance data is collected, provincial statutes provide protection for those interests, in part, by legislating when and what information can be shared. These statutes reflect the assumption that provincial or federal bodies, or alternately regional health boards, are the entities which require the information. For example, Manitoba’s *Public Health Act*<sup>56</sup> permits routine sharing with the federal government, and Alberta’s *Health Information Act*<sup>57</sup> permits agreements to share information with federal and/or provincial and territorial ministries, as well as regional health councils created pursuant to provincial legislation.<sup>58</sup> This would seem to enable effective sharing of health information when an Aboriginal community’s health programming is still being managed by FNIHB. Unfortunately, the potential effectiveness

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53 For a discussion of SARS as producing an opportune moment for federal movement into the field of public health generally, and evidence of provincial support for federal involvement see Kumanan Wilson & Christopher MacLennan, “Federalism and Public Health Law in Canada: Opportunities and Unanswered Questions” (2005) 14:2 Health L. Rev. 3.

54 See Gibson, *supra* note 48 at 125-7.

55 *Constitution Act, 1867 (UK)*, 30 & 31 Vict., c.3, s.91(24), reprinted in R.S.C. 1985, App. II, No.5.

56 *Public Health Act*, C.C.S.M., c. P210, s. 12.2(1).

57 *Health Information Act*, R.S.A. 2000, c.H-5, s.39(1).

58 See e.g. under the *Regional Health Authority Act*, R.S.A. 2000, c.R-10.

is undermined because provincial health databases are inconsistent in their identification of Aboriginal individuals, and so even if a province has legislation which permits sharing data, and does share this data with FNIHB, the information is likely to be incomplete.<sup>59</sup> Together, this leaves considerable opportunity for disconnections between collection and analysis, and public health planning, delivery and evaluation.<sup>60</sup>

The addition of a third level of government which designs and administers public health programming, that of First Nations under Transfer/Targeted Agreements, further complicates these poorly coordinated relationships. Although provincial legislation typically permits routine sharing of health surveillance information at least between health authorities,<sup>61</sup> there is no legislative recognition of a right of transferred First Nations to receive provincially collected data.

Communicable disease control provides an excellent example of the compounded difficulties which may arise under health transfer. As noted above, any community who wishes to engage in a Transfer/Targeted Agreement is mandated to include taking over not only the Environmental Health programme, but also the administration of Communicable Disease Control and Immunization from FNIHB. So all such First Nations are responsible for addressing on reserve CDC situations. However, provinces are not necessarily integrated into this arrangement, despite their being a key collection point for relevant information. As noted above, Manitoba's legislation permits sharing of information with the federal government – in practice, Manitoba Health notifies FNIHB of any CDC cases, FNIHB notifies its regional office, and the regional office contacts the on-reserve caregiver.<sup>62</sup> This results in the caregiver being able to take appropriate action with the infected individual, but does not expressly include bringing those who plan and evaluate on-reserve CDC programming into the information circle. Alberta's health information legislation, on the other hand, has no provision for sharing information with First Nation health programmers, yet its practice is for provincial authorities

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59 See e.g. Dr. Josée G. Lavoie *et al.*, *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report: Volume 3, Appendices* (Winnipeg: Centre for Aboriginal Health Research, 2005) at 25-8.

60 *Supra* note 16 at 13.

61 See e.g. *Public Health Act*, R.S.P.E.I. 1988, c. P-30, s.8

62 Dr. Josée G. Lavoie *et al.*, *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report: Volume 3, Appendices* (Winnipeg: Centre for Aboriginal Health Research, 2005) at 56.

to contact transferred First Nations directly<sup>63</sup>. This is a sensible, but legally questionable, approach, which may expose provincial authorities to suits based on privacy claims. On the other end of the continuum is New Brunswick, which does not provide official notification of CDC cases to reserves, having taken the position that public health on reserves is absolutely under federal jurisdiction, including everything from notification to tracking.<sup>64</sup> In practice, however, CDC information is sometimes communicated through individual relationships between provincial staff and on-reserve health care providers,<sup>65</sup> perhaps taking advantage of the provision in New Brunswick's *Public Health Act* which permits disclosure to physicians and nurses.<sup>66</sup> Where does this leave us? As the system stands, the worst outcome is illustrated by a case study in Lavoie's 2005 evaluation of the health transfer programme. Lavoie documented encountering one Aboriginal community with a very high proportion of injection drug-users.<sup>67</sup> (Lavoie does not identify the community nor its province to protect the community's privacy interests.) As the sharing of needles is believed to be a key source of the escalating HIV rates in Aboriginal communities,<sup>68</sup> Lavoie considered how the public health surveillance system would engage the community if a member was diagnosed with HIV or Hepatitis C. In this instance, she found a disturbing lack of intergovernmental coordination.

As provincial public health authorities do not notify the on-reserve Health Centres of on-reserve CDC cases to allow for contact tracing and follow up, it is impossible for the Health Centre staff to ascertain

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63 *Ibid.*

64 *Ibid.*

65 *Ibid.*

66 *Public Health Act*, S.N.B. 1998, c.P-22.4, s. 66(2).

67 Lavoie, *et al.*, *Final Report*, *supra* note 13 at 82.

68 See e.g. Canada, Public Health Agency of Canada, "Understanding the HIV/AIDS Epidemic among Aboriginal Peoples in Canada: The Community at a Glance", *HIV/AIDS Epi Notes* (December 2004), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/epiu-aepi/epi-note/>>. New diagnosis of AIDS among Aboriginal people went from 2.9% of diagnosed cases in 2000, to 17.2% of newly diagnosed cases as of June 2006. See Canada, Public Health Agency of Canada, *HIV and AIDS in Canada: Surveillance Report to June 30, 2006* (Ottawa, Ont.: Public Health Agency of Canada, 2006) at 40, online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/aids-sida/haic-vsac0606/pdf/haic-vsac0606.pdf>>.

the extent of the epidemic. Conversely, as the province does not do contact-tracing on reserve, Band members are left in a potentially no care situation until later on in the onset.<sup>69</sup>

Overall, Lavoie reached the conclusion that:

As the steward of the system, FNIHB has no mechanism to assess whether this First Nation's experience is unique, how many reserves and communities may be facing this crisis, and the extent to which Hepatitis C and HIV risk may be on the rise.<sup>70</sup>

Lavoie's conclusions appear to be supported by her data. Overall, there is no consistency in the sharing of data, leaving both transferred First Nations under Transfer/Targeted Agreements and FNIHB with varying levels of information upon which to plan, evaluate, and make decisions. Any possibility of FNIHB engaging this gap through enacting national policy is undermined by provincial variation. Researchers involved with curtailing the spread of tuberculosis (TB), which has re-emerged as a major public health issue within some Aboriginal communities,<sup>71</sup> are alarmed by these growing trends towards a fragmented surveillance system. Although supportive of health transfer generally, and of the belief that TB rates will only fall if there is, among other factors, "community involvement in disease management,"<sup>72</sup> they urge "caution...in terms of TB control."<sup>73</sup> Drawing upon the lack of central coordination as having been "a major obstacle" to controlling recent outbreaks of TB in the Northwest Territories and Nunavut,<sup>74</sup> they point to the urgency of addressing how such coordination is possible in the context of greater decentralization, before TB reaches a crisis situation.

As practices stand, public health surveillance is patchy. Successful communications – and so effective use of information – appear ad hoc and based on the good will of persons within the system, or else are formalized but

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69 Lavoie, *et al.*, *Final Report*, *supra* note 13 at 82.

70 *Ibid.* at 83.

71 J. Mark Fitzgerald, Lei Wang & R. Kevin Elwood, "Tuberculosis: 13. Control of the disease among aboriginal people in Canada" (2000) 162:3 CMAJ: Canadian Medical Association Journal 351 at 351.

72 *Ibid.* at 351.

73 *Ibid.* at 354.

74 *Ibid.*

indirect, or have unclear legal footing. Absent provincial legislative changes to enable a more direct and useful relationship with communities operating under Transfer/Targeted Agreements, public health surveillance is likely to continue to flounder. Such legislative changes would have to be very carefully undertaken, given the augmented privacy issues which may arise in smaller communities. I return to this point, and to the issue of data collection generally, in the final section of this paper.

### **3. New gaps which are likely to emerge under transfer**

#### Gaps in funding security

There are ways in which the health needs of Aboriginal people may become more vulnerable when a community enters a transfer agreement. Probably the most troubling possibility is the susceptibility of health program funding to seizure by third parties, leaving a First Nation responsible for programming which it no longer has the funds to deliver. This emergent vulnerability is not a thought-experiment: one instance of such a seizure has already taken place and been upheld by the Supreme Court of Canada.

In *McDiarmid Lumber Ltd. v. God's Lake First Nation*<sup>75</sup>, God's Lake First Nation had entered into a variation of a General Agreement, which included delivering certain health service programming as well as education and social services. God's Lake First Nation also had a private debt to a construction supply company of \$1,223,109. This company served a notice of garnishment on the First Nation's bank account. At that time, of the \$548,811.55 in the Band's account, all but \$29,973.00 were funds transferred to administer programs under the General Agreement. God's Lake First Nation argued that the funds were protected from garnishment under a shielding provision of the *Indian Act*, which applies to property given to a band under a treaty or agreement with the Crown. The majority of the Supreme Court of Canada disagreed, finding that the term "agreement" referred only to agreements struck to clarify the terms of a treaty.<sup>76</sup> The dissent, on the other hand, interpreted "agreement" to refer to any agreement entered into to fulfill "Par-

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75 *McDiarmid Lumber Ltd. v. God's Lake First Nation*, 2006 SCC 58, [2006] 2 S.C.R. 846 [*God's Lake* cited to S.C.R.]. For a detailed discussion of this case, see Constance MacIntosh, "Developments in Aboriginal Law: The 2006-2007 Term" (2007) 38 *Sup.Ct. L. Rev.* 1 at 2-18.

76 *God's Lake*, *ibid.* at paras. 27-41.

liament's legislative assumption of responsibilities for Indian bands under s.91(24) of the *Constitution Act, 1867*...<sup>77</sup> As such, the dissent would have found a shield for any funds transferred to First Nation's control for administering "on-reserve essential public services including housing, education, infrastructure, health and welfare."<sup>78</sup>

The harsh irony here is that had control not been transferred, the funds earmarked for the very same set of programming would not be vulnerable to seizure, as the Crown is exempt from the execution of judgements in garnishment proceedings.<sup>79</sup> So, by taking responsibility for planning and delivering health programming, the funding which enables that programming becomes vulnerable. In the case of God's Lake First Nation, the Crown had argued that the funds had to fall within the shield, as otherwise the garnishment "could lead to ... a loss of [the Bands] capacity to deliver essential services."<sup>80</sup>

God's Lake is a community which is desperately in need of improvements to health, accounting for 10% of all tuberculosis cases in Manitoba.<sup>81</sup> It is exactly the sort of community which the health transfer initiative was intended to benefit through local control over local health situations. Recall that under these General Contribution agreements, the band itself cannot deviate its spending from the agreed upon budget<sup>82</sup> – it has no power to redirect the funds to serve private debts. Indeed, in this case, the Band could only make disbursements through a third party financial management company, and that company could only authorize payments pursuant to the agreement. But this sort of contractual commitment does not bind third parties.

This decision could have profound effects upon health transfers into the future, and leaves the federal government with three choices. It could enact protective shielding legislation, refuse to enter into transfer agreements with First Nations that are not particularly solvent, or allow the status quo to persist and leave essential funding vulnerable to third party seizure. Thus far it has followed the third choice.

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77 *Ibid.* at para. 86.

78 *Ibid.* at para. 87.

79 *Garnishment, Attachment and Pension Diversion Act*, R.S.C. 1985, c.G-2, s.28; *Crown Liability and Proceedings Act*, R.S.C. 1985, c. C-50, s. 29.

80 *God's Lake*, *supra* note 75 at para. 83 (per Binnie J. citing from the Attorney General of Canada's factum).

81 *Ibid.* at para. 83.

82 *Ibid.* at para. 100.

### Gaps resulting from vulnerability to Provincial cost-shifting

A second area in which new gaps may emerge relates to the division of powers, as buttressed by statutory arrangements, between provincial governments and the federal government. First Nations under transfer are now extremely vulnerable to their budget eroding due to health care decisions made by provinces. Under the *Canada Health Act*<sup>83</sup> provinces have agreed to deliver “insured health services” to all persons normally resident in the province, which includes Aboriginal residents regardless of whether they live on or off reserve, in return for a federal transfer of funds. “Insured services” include “hospital services” and “physician services.”<sup>84</sup> As the formula for the federal transfer centres around provincial population, not actual costs,<sup>85</sup> provinces are motivated to reduce the actual cost of insured services.

As provinces make decisions to shift the location or delivery of care by reducing hospital beds, closing hospitals, and shortening hospital stay time, these changes theoretically result in care being delivered through less expensive means. With the provincial savings comes greater demand on First Nation health budgets, as the care shifts to taking place on the reserve. To balance the shifting availability and form of service delivery, they need more community health nurses, and more home care. They also require greater funds to cover greater travel distances to receive hospital care.<sup>86</sup> Communities which have not entered into transfer agreements will obviously submit claims for extra travel to FNIHB, and requests will be made for increased home care and nursing support to reflect the shifts. Communities which have entered transfer agreements, however, will have already established a largely non-negotiable budget which is subject to a non-enrichment clause. The federal government has been very clear that in its opinion, its responsibilities for transferred programming are entirely dictated in the transfer agreements themselves. The risk of such cost-shifting falls on the shoulders of the First Nations. In Health Canada’s core documents on transfer, they write:

The Transfer Agreement is a legal document. It formalizes the relationship between the Community and FNIHB in terms of delivery of

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83 *Canada Health Act*, R.S.C. 1985, c.C-6.

84 *Ibid.* at ss. 2, 4.

85 *Federal-Provincial Fiscal Arrangements Act*, R.S.C. 1985, c. F-8, ss.14-16.

86 Lavoie *et al.*, *Final Report*, *supra* note 13 at 90-1.

health programs and services and sets out the terms and conditions of the arrangement between the two parties in this area.<sup>87</sup>

With the transfer of risk, the stability of First Nations health programming is therefore far more vulnerable to health care cost-shifting decisions made by provinces than communities which remain outside the transfer regimes. We likely will see itinerant gaps appearing in First Nation health care programming as funds prove inadequate to meet rising costs resulting from provincial cost-shifting activities.

### Gaps arising from Band Councils' exercises of discretion

As noted above, although a band seeking to enter into a Transfer/Targeted Agreement must develop a plan that meets FNIHB's satisfaction prior to the Agreement being signed, after the transfer occurs bands have discretion to reallocate all funding, except the funding provided for the three mandatory programs.<sup>88</sup> The purpose behind this discretion is clearly to enable bands to respond to changing priorities and circumstances, and so keep their programming relevant over the three to five year lifespan of a Transfer/Targeted Agreement. However, there is the potential for bands to exercise this discretion in a fashion which effectively discriminates or otherwise fails to support already vulnerable populations. Findings in some research studies predict that funding originally allocated to mental health and disability supports may be the first line of programming to be cut<sup>89</sup> when bands are faced with an inadequate budget to meet their costs. In Durst and Bluechartd's study of Aboriginal people with disabilities, they found that as

the Bands and Tribal Councils determine how resources are allocated [they] ...can deny individual access to buildings, employment, training opportunities and services if they choose to apply resources elsewhere.<sup>90</sup>

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87 Health Canada, *Health Services Transfer*, *supra* note 21 at 28.

88 See Health Canada, "Contribution Agreements", *supra* note 20.

89 Douglas Durst & Mary Bluechartd, *Urban Aboriginal Persons with Disabilities: Triple Jeopardy!* (Regina, Sask.: Social Policy Research Unit, University of Regina, 2001) at 61 [Durst, *Triple Jeopardy*].

90 Douglas Durst & Mary Bluechartd, "Aboriginal People with Disabilities: A Vacuum in Public Policy" (2004) 6 Saskatchewan Institute of Public Policy: SIPP Briefing Note 1 at 5 [Durst, "Vacuum"].

Durst's conclusion was that, "[i]n this research, it was determined that the right to self-government by First Nations superseded the rights of the First Nations person with a disability."<sup>91</sup>

Can a band council simply reallocate the funds originally committed to serving its disabled population, and, in an extreme case, choose not to allocate any on-reserve housing for – or make housing appropriate for – disabled band members? Or can a band council refuse to allow a band member with HIV to reside on reserve, or decide not to fund their health programming needs? Arguably, yes, even if the decision was shown to be based in discriminatory or prejudiced reasoning. The decisions of Band Councils are presumptively made exempt from scrutiny under the *Human Rights Act*.<sup>92</sup> In particular, section 67 states that "[n]othing in this Act affects any provision of the *Indian Act* or any provision made under or pursuant to that Act."

Not surprisingly, section 67 has been read narrowly by Canadian courts, and found to only erect a shield against the operation of the Act where a Band Council exercises an authority which is explicitly recognized in the *Indian Act*. These powers include making decisions "to provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases"<sup>93</sup> as well as to make decisions about the residence of band members.<sup>94</sup> As a result, despite the fact that the Federal Court of Appeal found there was a prima facie case that a woman was denied housing by her Band Council based on her gender and marital status, and the race of her spouse, this decision was immune from Code scrutiny.<sup>95</sup> The Court further found that once triggered, this immunity arose in a broad range of decision-making circumstances.

In my view, the immunity that section 67 gives the Gordon Band Council does not depend upon whether its decision to deny housing to Ms. Laslo is recorded formally in the minutes of the meetings, or whether some aspect of the decision making process was based on a housing policy or delegated to a committee, or whether it was based on a bylaw enacted under section 81.<sup>96</sup>

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91 *Ibid.*

92 *Canadian Human Rights Act*, R.S.C. 1985, c. H-6.

93 *Indian Act*, R.S.C. 1985, c. I-5, s. 81(1)(a).

94 *Ibid.* s. 81(1)(p.1).

95 *Canada (Human Rights Commission) v. Gordon Band Council*, [2001] 1 F.C. 124, 190 D.L.R. (4<sup>th</sup>) 418 (C.A.) [*Gordon Band* cited to F.C.].

96 *Ibid.* at para. 30.

Clearly the immunity would extend to any body making decisions about “the health of residents,” “contagious disease” and housing. Without access to Code protection against discrimination in decisions about providing for health, or containing disease, and the cancellation of the Charter challenge program, vulnerable band members are unlikely to have an effective venue if such discriminatory practices do surface. The cascading consequences of such decisions would be that disabled band members may be forced to move away to urban centres. There, if they wish to access support programs, physical aids and services which are typically provided through provincial programming, status Indians who are members of transferred bands are outside of provincial responsibility, and must apply to their Bands for approval for payment of funds.<sup>97</sup> And then attend the provincial department or other service organization for the needed service or aid.<sup>98</sup> This approval is, obviously, once again at the discretion of the band. In Durst’s study, he concluded that when it comes to such displaced individuals, “...their likelihood of receiving Band sponsorship is slim.”<sup>99</sup>

So, arguably, the band council government which has taken on the responsibility for the public health needs of its band members could make choices which, intentionally or not, have the effect of essentially disenfranchising some of its more vulnerable members in a manner which would be unacceptable if a state actor was making the decision. One would hope that such an outcome would never come to pass, and, overall, to maintain perspective, it is important to acknowledge that self-government arrangements have been viewed generally positively by aboriginal persons with disabilities,<sup>100</sup> and that Canada itself has not done a satisfactory job in meeting the needs of disabled Aboriginal people.<sup>101</sup> However, given the fact that the transfer process creates shortfalls in funding, money will be pulled from programming which is considered, by those who exercise discretion, less vital. As a result, such gaps may well emerge, and be unassailable absent funding for a Charter challenge.

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97 Durst, *Triple Jeopardy*, *supra* note 89 at 27.

98 Durst, “Vacuum”, *supra* note 90 at 5.

99 Durst, *Triple Jeopardy*, *supra* note 89 at 94.

100 *Ibid.* at 63.

101 See e.g. MacIntosh, “Jurisdictional Roulette”, *supra* note 6 at 203-5.

#### 4. Gaps which are likely to close under transfer

##### Introduction: The challenge of evaluation

It is challenging to identify specific improvements, or closures of health gaps, which have already occurred in transfer communities. The difficulty lies, in part, in the lack of comparative information. Ideally, one would compare health status in a number of communities over time, both those who do and do not enter into transfer agreements. And, one would develop various indexes – some of which would measure traditional criteria, and others of which would reflect Aboriginal conceptions of health in so far as there may be differences. When Prof. Lavoie and others at the Aboriginal Health Research Centre were granted the federal contract to evaluate the health transfer programme in 2005, they had intended to conduct a comparison between communities with and without Transfer/Targeted Agreements over time. Upon requesting this comparative data from FNIHB, however, the researchers “were advised that this type of analysis would not be possible because the data is simply not available.”<sup>102</sup> Although FNIHB retains data for non-transferred communities and imposes very specific reporting requirements on transferred communities (which fulfill its reporting responsibilities to the Treasury Board), the collected data largely reflects administrative matters.<sup>103</sup> Of all the communities that have completed their three to five year term under a Transfer/Targeted Agreement and have submitted their final reports, only about 20% include some sort of longitudinal outcome analysis and only 36%<sup>104</sup> actually refer back to the public health goals outlined in their community health plans. This omission, and the difficulty it causes for evaluating the effectiveness of health transfer, had already been observed by the Auditor General, in 1997,<sup>105</sup> but it remains outstanding.

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102 Lavoie *et al.*, *Final Report*, *supra* note 13 at 27.

103 Health Canada, First Nations, Inuit and Aboriginal Health, *Transferring Control of Health Programs to First Nations and Inuit Communities: Handbook 3 – After the Transfer – the New Environment* (Ottawa, Ont.: Health Canada, 1999) at 17-21.

104 Josée Lavoie, “From the local to the national: Opportunities and challenges associated with First Nation Health Transfer Evaluations” *Canadian Journal of Program Evaluation* [forthcoming] [Lavoie, “From the local”]

105 Office of the Auditor General of Canada, *1997 October Report of the Auditor General of Canada* (Ottawa, Ont.: Office of the Auditor General of Canada, 1997) at 13.55-13.74.

As a result, a detailed analysis based on actual quantifiable changes – or a lack of changes – in transfer communities versus communities which have not transferred over the last 20 years is not possible. Indeed, after reviewing the highly fragmented character of health programming, and the complexity of assigning improvements to any individual program, Lavoie concluded that

the local evaluation process will never be able to meet the national need for evidence on the performance of the HTP in improving outcomes, because of the fragmentation of funding along different programs that are expected to be evaluated separately, diversity of needs, community size and approaches and barriers to accessing information.<sup>106</sup>

In other words, any attempt to quantify change, and attribute that change to participation in health transfer, will likely be extremely speculative due to the multiple factors which may be involved. However, more qualitative assessments are possible.

### Qualitative Improvements to Community Well-being

In their case study of nine Aboriginal health systems in Canada, Lemchuk-Favel and Jock found their research supported the conclusion that:

Aboriginal ownership and control of health services can contribute to a climate of self-empowerment in the community and can improve access to services through a supportive culturally-appropriate environment.<sup>107</sup>

Self-reporting from transferred communities across Canada shows trends which are consistent with Lemchuk-Favel and Jock's conclusions. Most communities, in their five year reports, did include information on how community members have perceived their health situation to have changed under their Transfer/Targeted Agreement. Most evaluations record that those surveyed expressed experiencing a sense of empowerment and improved accessibility.

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106 Lavoie, "From the local", *supra* note 104.

107 Lemchuk-Favel & Jock, *supra* note 4 at 29.

How does self-empowerment relate to public health? There have been two studies in British Columbia which link Aboriginal control over governance administration, including health programming, to youth suicide rates within Aboriginal communities. The first set of research findings was published in 1997.<sup>108</sup> The publication received considerable attention because its data countered the perception that youth suicide is a pan-Aboriginal problem. Although suicide rates for Aboriginal youth were statistically 3 to 5 times the provincial average, the study determined that these suicides did not occur at the same rate in every community. In fact, of the 196 communities surveyed over a five year period, 111 had no known suicides, and 90% of the suicides occurred in less than 10% of the communities.<sup>109</sup> So, contrary to public perception, high Aboriginal youth suicide rates are an extremely localized phenomenon, occurring at truly shocking rates within specific communities.

The second reason the study garnered so much attention was that it found that the more measures of community control exercised by an Aboriginal community, the lower the suicide rates. Where a community exercised a level of self-government, the suicide risk rate was assessed to be lowered by 89%; where there was control over health services, the risk was assessed to be lowered by 29%.<sup>110</sup> Due in part to interest from policy makers, the study's authors, Chandler and Lalonde, conducted a broader follow-up research project which is due to be published in 2009.<sup>111</sup> In this study, they considered data spanning 1993 to 2000, and found, once again, that rates of youth suicide varied dramatically between bands or tribal councils, that 90% of the suicides occurred in 12% of the bands, and over half the communities had no youth suicides during the study period.<sup>112</sup> In response to questions raised after the first study, the researchers included data on a number of other factors, and considered community wealth, housing, and education,

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108 Michael J. Chandler & Christopher Lalonde, "Cultural Continuity as a Hedge against Suicide in Canada's First Nations" (1998) 35:2 *Transcultural Psychiatry* 191.

109 *Ibid.* at 206.

110 *Ibid.* at 212.

111 Michael J. Chandler & Christopher E. Lalonde, "Cultural Continuity as a Moderator of Suicide Risk Among Canada's First Nations" in L. Kirmayer & G. Valaskakis, eds., *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*, University of British Columbia Press [forthcoming].

112 *Ibid.* at 12.

as well as rural versus urban proximity, but found these factors were not statistically significant.<sup>113</sup> Their conclusion was that suicide rates were “strongly related” to what the researchers called “measures of ‘cultural continuity,’” including attempts to regain legal title to traditional lands, efforts to establish self-government, and the assertion of control over education, social services, and health delivery services.<sup>114</sup> Obviously there is a risk, here, of not knowing the relationship between “the chicken and the egg,” but there clearly is a correlation between community self-governance activities, including control over public health services, and suicide rates.

### Overcoming the Data Problem

The lack of relevant statistical data has engendered other difficulties, which may be addressed as a result of the transfer process. Current difficulties include the challenge, faced by transfer communities and FNIHB alike, of designing and delivering public health programming without accurate and comprehensive targeted health data. A 2006 survey of existing data sources, created both by state as well as non-governmental and Aboriginal organizations, concluded that there is a patchwork of reports on Aboriginal health available, all of which suffer from variable coverage issues and incomplete reporting.<sup>115</sup> Indeed, until the (poorly participated in) 1991 Aboriginal Peoples Survey (APS), which was repeated in 2001, there was no national information on the social, economic and health conditions of Aboriginal people.<sup>116</sup> These gaps clearly impact upon FNIHB’s ability to identify and develop appropriate national strategies and targeted programmes generally. As to communities with Transfer/Targeted Agreements, the 2005 evaluation of the health transfer program found they lacked “access to reliable longitudinal health information on their community on which to base their planning”<sup>117</sup> as well as a mechanism for receiving information from provincial data bases so that they can become aware of service usage off-reserve by

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113 *Ibid.* at 17.

114 *Ibid.* at 18.

115 Marcia Anderson *et al.*, “Discussion Paper No. 18: First Nations, Inuit and Métis Health Indicators in Canada” (Melbourne: Onemda VicHealth Koori Health Unit, 2006) at 20 [Anderson *et al.*].

116 Edward Ng, “Disability among Canada’s Aboriginal Peoples in 1991” (1996) 8:1 Health Reports 25 at 25.

117 Lavoie *et al.*, *Executive Summary*, *supra* note 30 at 14; Lavoie *et al.*, *Final Report*, *supra* note 13 at 79.

their members.<sup>118</sup> So there is currently a lack of comprehensive data at the state level, and a lack of specific information at the community level.

Ironically where Canada has collected data under the authority of the *Statistics Act* which includes information at the regional level, this data is only partially accessible to Aboriginal communities. The problem stems from legislative restrictions on disseminating non-aggregated information, where that information's collection was authorized pursuant to the *Statistics Act*. The *Statistics Act* does not recognize First Nations as entities with which the Minister is authorized to enter into an agreement to share disaggregated data.<sup>119</sup> As a result, whereas provinces and municipal departments may receive disaggregated data for their health planning purposes (as long as they have statutory privacy measures in place)<sup>120</sup> First Nation communities can only access summative data, like any member of the public, from *Statistics Act* surveys. Ironically, this includes the data collected for the Aboriginal Peoples Surveys (APS),<sup>121</sup> Canada's first major effort to create a comprehensive picture of the needs of Aboriginal peoples in such areas as health and housing. For example, if the Mi'kmaq community of Indian Brook, who participated in the APS, sought to access the health data collected about their community, they would find, like any other member of the public could, that 21.7% of adults report being diabetic, but would be left in the dark as to the percentage with communicable diseases or cancer, as the rates for these health concerns were suppressed to ensure confidentiality,<sup>122</sup> as required by the *Statistics Act*. There is a provision under the *Statistics Act* to release information "relating to a person" if this disclosure is consented to in writing,<sup>123</sup> but such an approach is clearly unwieldy and, if pursued as a route to collect other-

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118 *Executive Summary, ibid.* at 9.

119 *Statistics Act*, R.S.C. 1985, c. S-19, ss. 10, 11, 17.

120 *Ibid.*, ss. 3(b), 12.

121 National Aboriginal Health Organization, *Making a Difference: National Aboriginal Health Organization Submission to the Commission on the Future of Health Care in Canada* (Ottawa, Ont.: National Aboriginal Health Organization, 2001) at 19. O'Neil and Blanchard find that "...Statistics Canada is of the view that it is bound by statutory regulations that govern access to raw data to external agencies" which results in limiting access to First Nations. O'Neil & Blanchard, *supra* note 16 at 28.

122 See Canada, Statistics Canada, "2001 Aboriginal Peoples Survey Community Profiles – Indian Brook 14, Nova Scotia" (Ottawa, Ont.: Statistics Canada, 2001)..

123 *Statistics Act, supra* note 119, s. 17(2)(b).

wise confidential data about community members, is likely to produce, once again, a very incomplete patchwork of data.

An emergent response to this dilemma is the First Nations Statistical Institute, created under the authority of the 2006 *First Nations Fiscal and Statistical Management Act*.<sup>124</sup> The Institute is moving towards being operational, with its first Board members having been appointed in August of 2007. Pursuant to its enabling statute, the Institute's purposes include providing statistical information on the "social conditions" of "Indians and other members of First Nations" and "other persons who reside on reserve lands."<sup>125</sup> In particular, it has the authority to enter into agreements with aboriginal governments to collect, compile and share data regarding "health and welfare,"<sup>126</sup> but, like the *Statistics Act*, the information must not be delivered in a form which can "be related to any identifiable individual, business or organization."<sup>127</sup> So the first positive outcome which the Institute may enable for obtaining relevant health planning information is a mandate to work with First Nation communities to identify the sorts of data which they need, and then operationalize the data collection. Intriguingly, the enabling legislation appears to permit agreements to share data with enough markers attached to allow First Nations to effectively access information about their specific communities. Although the Institute is generally prohibited from disclosing information which "can be related to any identifiable individual, [or] first nation...,"<sup>128</sup> this prohibition does not apply when such information is disclosed "for the purposes of communicating information in accordance with the conditions of an agreement..."<sup>129</sup> The Institute thus promises an infrastructure for enabling First Nations to collect and analyze community-specific and appropriate health and social data.

However, the Institute remains an extension of the Canadian government, and many Aboriginal communities or political organizations are extremely hesitant to participate in any state run initiative to address the data gap. The collection and dissemination of data from or about Aboriginal people has become a highly contentious area.<sup>130</sup> For example, only 123 First

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124 *First Nations Fiscal and Statistical Management Act*, S.C. 2005, c. 9, s. 89.

125 *Ibid.*, s. 102(a).

126 *Ibid.*, s.103(1), (2)(c).

127 *Ibid.*, ss.103(3), 104(1).

128 *Ibid.*, s.106(1)(b).

129 *Ibid.*, s. 106(1).

130 For example, the Assembly of First Nations (AFN) has passed several resolutions

Nation communities participated in the APS due to disputes over whether Aboriginal communities or the federal government would have the right to control the collected data.<sup>131</sup> This battle over control reflects the history of data collection about Aboriginal people. Until the late 1990s, data collection had been largely “one-sided,” that is, collected by academics, government officials, or industry to pursue their self-identified purposes or research agendas, often with questionable benefit to the surveyed community.<sup>132</sup> Adding insult to injury is the fact that researchers did not necessarily adhere to ethical practices, such as obtaining informed consent, or restrict their research to the matters which had been communicated to communities.<sup>133</sup> As the National Aboriginal Health Organization writes, “The gathering of

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regarding their commitment to only support research or data collection that complies with the OCAP principles. As a result, despite a 15-month negotiation period with Statistics Canada, the AFN ultimately decided it could not support or participate in the APS. See Assembly of First Nations, “Resolution No. 9/99: Aboriginal Peoples Survey II and First Nations and Inuit Longitudinal Health Survey Integrated Process” (Ottawa, Ont.: Confederacy of Nations, April 12-14, 1999), online: Assembly of First Nations <<http://www.afn.ca/resolutions/1999/Confederacy%20Resolutions/res9.htm>>; Assembly of First Nations, “Resolution No. 72/2000: First Nations and the Aboriginal Peoples Survey (APS)” (Ottawa, Ont.: Confederacy of Nations, December 13-14, 2000), online: Assembly of First Nations <<http://www.afn.ca/resolutions/1999/Confederacy%20Resolutions/res9.htm>>; Assembly of First Nations, “Resolution No. 32/2004: Support for the First Nations Regional Longitudinal Health Survey (RHS) and First Nations Jurisdiction in Information and Research” (Charlottetown, P.E.I.: Assembly of First Nations, July 20-22, 2004), online: Assembly of First Nations <<http://www.afn.ca/article.asp?id=369>>; Anderson *et al.*, *supra* note 115 at 20; O’Neil & Blanchard, *supra* note 16 at 28.

131 Harvard Project on American Indian Economic Development, *Review of the First Nations Regional Longitudinal Health Survey (RHS) 2002/2003* (Cambridge, Mass.: Harvard Project on American Indian Economic Development, 2006) at 21, online: First Nations Regional Longitudinal Health Survey <[http://www.rhs-ers.ca/english/pdf/rhs2002-03reports/rhs\\_harvard\\_independent\\_review.pdf](http://www.rhs-ers.ca/english/pdf/rhs2002-03reports/rhs_harvard_independent_review.pdf)> [Harvard Project].

132 Constance MacIntosh, “Indigenous Self-Determination and Research on Human Genetic Material: A Consideration of the Relevance of Debates on Patents and Informed Consent, and the Political Demands on Researchers” (2005) 13 *Health L.J.* 213 at 221-5.

133 MacIntosh, *ibid.*; O’Neil & Blanchard, *supra* note 16 at 41.

information and its subsequent use are inherently political ... [and so] it is met with resistance in many quarters."<sup>134</sup> One response to this history has been for Aboriginal communities to develop strategies and positions to try to control all research regarding community members, including the use and dissemination of all information arising from research. The acronym for this approach is "OCAP" – ownership, control, access and possession.<sup>135</sup> This is where the First Nations Statistical Institute may run into problems, as its enabling statute states it "shall publish and make publicly available"<sup>136</sup> the statistical information which it collects under its general mandate. Although such information must be not published in a fashion which can "be related to any identifiable individual, business or organization,"<sup>137</sup> First Nation communities may still be hesitant to work with the Institute given the statute's clear requirement that information *is* to enter the public sphere, whether source communities like it or not, thus disregarding the OCAP principles.

However, it appears that First Nations are in the process of developing a solution to the data problem, one that goes hand-in-mitt with the responsibilities assumed under health transfer pursuant to Transfer/Targeted Agreements. Having found the terms of the *Statistics Act* to create an unacceptable governance framework, due to its approach to control and access, the Assembly of First Nations obtained funding, primarily from FNIHB, to conduct its own survey, the First Nations Regional Longitudinal Health Survey. [RHS]<sup>138</sup> Their plan is to conduct a longitudinal and cross-sectional health survey on four year cycles which captures both regional and national

134 First Nations Centre, *OCAP: Ownership, Control, Access and Possession* (Ottawa, Ont.: National Aboriginal Health Organization, 2007) at 3, online: National Aboriginal Health Organization

<[http://www.naho.ca/firstnations/english/documents/FNC-OCAP\\_000.pdf](http://www.naho.ca/firstnations/english/documents/FNC-OCAP_000.pdf)> (endorsing a quote from the Royal Commission on Aboriginal Peoples).

135 Brian Schnarch, "Ownership, Control, Access and Possession (OCAP) or Self-Determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities" (2004) 1:1 *Journal of Aboriginal Health* 80.

136 *First Nations Fiscal and Statistical Management Act*, *supra* note 124 at s. 103(3).

137 *Ibid.*, s.103(3), 104(1).

138 The Regional Health Survey National team coordinates 10 regional partners, who administer the survey on behalf of the First Nations Information Governance Committee, a standing committee of the AFN Chiefs Committee on Health.

coverage.<sup>139</sup> The survey was piloted on a small scale in 1997. Following this trial, the survey was modified and operationalized nationally in 2002/2003, with the express purpose of collecting baseline data.<sup>140</sup> The RHS has been far more successful with its participation rates than has the APS. Whereas 238 First Nation communities participated in the 2002/2003 RHS, only 123 First Nations participated in the 2001 APS.<sup>141</sup>

The RHS has been designed to de-identify collected data, so as to bring it to the community level, where it can be given to the relevant community as a statistical chart.<sup>142</sup> However, as administered in 2002/2003, the sampling design did not meet the needs of community health programmers. First, off-reserve members of First Nation communities were excluded for budgetary reasons, and second, the samples from each community were too small to accurately portray many communities.<sup>143</sup> In its review of the 2002/2003 RHS, the Harvard Project on American Indian Economic Development found that:

Community health directors described a need for community rather than 'provincial' level data for documentation of need and development of indicators for program planning, program development and grant writing.<sup>144</sup>

Given that the survey was designed to enable community-specific data to be extracted, the capacity is clearly present for the RHS to be used as a tool to collect the relevant data, and so finally enable comprehensively informed public health programming at the community level. It is likely that, if funding is adequate, the RHS can indeed come to play this role as it develops and is further refined with each iteration.

### Closing the Relationship Gap with Provincial Agencies

Intriguingly, many community final reports/self evaluations of transfer indicate that community health improvements were in part the result of partnering or otherwise forming new relationships with provincial agen-

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139 Harvard Project, *supra* note 131 at 11.

140 *Ibid.* at 3.

141 *Ibid.* at 12, 21.

142 *Ibid.* at 33.

143 *Ibid.* at 16.

144 *Ibid.* at 48.

cies.<sup>145</sup> Indeed, as of 2005 almost 60% of transferred First Nations had established such linkages, primarily in the area of public health.<sup>146</sup> Where such cross-jurisdictional linkages would be unwieldy for FNIHB to negotiate on behalf of First Nations generally, it would appear that individual First Nation communities have taken advantage of their new authority over their community programming to bridge the gap. Such bridging is clearly also in the best interest of provinces, as reserve residents are mobile and access their health programming through a combination of provincial and reserve-based resources.

These linkages are extremely promising. Provinces have extensive experience in designing, delivering and evaluating public health programming, and so clearly make excellent guides, mentors and partners. As well, the jurisdictional fragmentation caused by the federal/provincial split in health provision for First Nations is in practice effectively minimized. These relationships may thus not only result in better public health programming, but also may result in cost-efficiencies as duplication of services is avoided, and best practices are shared.

British Columbia, where 164 of its 203 communities have transferred, may well be a flagship for such partnering relationships. The Province, Canada and the British Columbia Assembly of First Nations, the First Nations Summit and the Union of British Columbia Indian Chiefs, committed in 2005 to an agreement<sup>147</sup> focused upon building “effective working relationships” to improve health. This led to the development of a health plan<sup>148</sup> and a Memorandum of Understanding<sup>149</sup> for implementing that health plan

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145 Evaluations are summarized at Lavoie *et al.*, *Executive Summary*, *supra* note 30 at 16-7.

146 *Ibid.* at 13.

147 Canada, British Columbia & The Leadership Council, *Transformative Change Accord* (November 25, 2005), online: Government of British Columbia <[http://www.gov.bc.ca/arr/social/down/transformative\\_change\\_accord.pdf](http://www.gov.bc.ca/arr/social/down/transformative_change_accord.pdf)>.

148 British Columbia & First Nations Leadership Council, *The Transformative Change Accord: First Nations Health Plan, Supporting the Health and Wellness of First Nations in British Columbia* (November 27, 2006), online Vancouver Coastal Health <[http://www.vch.ca/aboriginalhealth/docs/Action\\_Plan.pdf](http://www.vch.ca/aboriginalhealth/docs/Action_Plan.pdf)>.

149 First Nations Leadership Council, Canada & British Columbia, *First Nations Health Plan: Memorandum of Understanding* (November 27, 2006), online: Government of British Columbia <[http://www.healthservices.gov.bc.ca/library/publications/year/2006/first\\_nations\\_mou.pdf](http://www.healthservices.gov.bc.ca/library/publications/year/2006/first_nations_mou.pdf)> [*First Nations Health Plan*].

which was signed in late 2006. This in turn, resulted, among other outcomes, in a contract for a health plan that was signed by all parties in June of 2007, and which is in effect to 2017.<sup>150</sup> A key component for actualizing the new relationships and improvements is transferred communities. The various plans identify them as having created key opportunities for improving linkages with provincial entities, and detail specific plans for developing and supporting community health planning and delivery with these communities.<sup>151</sup>

## Concluding Comments

Health transfer holds great promise for improving Aboriginal public health. It enables a viable route for finally getting through some of the jurisdictional impasses which are so often implicated as hindrances to improvement,<sup>152</sup> and maybe getting beyond problems caused by inadequate community level and national health data. However, the predictive examples described in this paper regarding continuing and emerging gaps illustrate that the process risks being primarily an exercise in administrative devolution. The goal of health transfer is to *improve health* by transferring control, not just transfer control. The means must not be conflated with the ends. Based on the findings of this paper, health transfer will be far more likely to spawn substantive improvements if it is conceived of as part of a continuing relationship, which needs nurturing and re-visiting as experiences accumulate and barriers persist. This forecast was clearly anticipated within the original three pillars of the Indian Health Policy of 1979, where the federal government would “maintain an active role in the Canadian health system as it affects Indians” and would be an “advocate of the interests of Indian communities”<sup>153</sup>. Whether this revisioning of the transfer process occurs is an open question.

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150 First Nations Leadership Council, Canada & British Columbia, *Tripartite First Nations Health Plan* (June 11, 2007), online: Government of British Columbia <[http://www.healthservices.gov.bc.ca/cpa/mediasite/pdf/tripartite\\_plan.pdf](http://www.healthservices.gov.bc.ca/cpa/mediasite/pdf/tripartite_plan.pdf)>.

151 See e.g. *First Nations Health Plan*, *supra* note 149 at 2-3.

152 MacIntosh “Jurisdictional Roulette”, *supra* note 6; MacIntosh “Testing the Waters”, *supra* note 43.

153 Health Canada 1979, *supra* note 10.