Aboriginal Quality of Life

Aboriginal Health Care in Northern Ontario

Impacts of Self-Determination and Culture

Bruce Minore
Mae Katt

IRPP

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Aboriginal Quality of Life / Qualité de vie des Autochtones

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With this publication, IRPP continues its research program Aboriginal Quality of Life, which includes a series of studies examining recent innovations in public policies, programs and partnerships involving Aboriginal people. This program builds on research on Aboriginal issues carried out as part of the Institute's Art of the State III project, notably the contributions of Evelyn Peters, Joyce Green and Ian Peach, and John Richards, to the 2007 IRPP volume *Belonging? Diversity, Recognition and Shared Citizenship in Canada.*

The situation of many of Canada's Aboriginal people is one of the country's most pressing public policy questions. Based on a range of measures, from income and unemployment levels to health indicators, there are significant gaps in life chances between many Aboriginal and non-Aboriginal Canadians. There has been progress in some areas — for example, in the proportion of Aboriginal people who have completed post-secondary education. Nonetheless, measures such as the United Nations Human Development Index continue to underline the unacceptable disparities between Aboriginal and non-Aboriginal people in Canada. Self-government agreements signed during the past 30 years or so, particularly in the North, hold promise of a better future for the First Nations who have acquired greater community autonomy. But the majority of Aboriginal people, notably those who live in cities, are not covered by such agreements; for them, there is a need for other approaches and — above all — renewed political will.

In this study, Bruce Minore and Mae Katt analyze moves towards Aboriginal self-determination in the important policy field of health. They define self-determination in this context as involving the creation, maintenance and control of services in response to needs the community has identified. In almost three-quarters of the 599 First Nations and Inuit communities where current policies allow some form of self-determination with respect to health, services are delivered by organizations controlled by Aboriginal people. Minore and Katt's study is centred on community crisis teams in the Nishnawbe-Aski First Nations in northern Ontario. The teams, which

resulted from the suicide crisis within the region, are funded through the Aboriginal Healing and Wellness Strategy, a joint Aboriginal/Ontario initiative. The authors recount that when processes to manage a diverse group of programs across the province were standardized, some of the local autonomy that is essential to such community-based programs was curtailed. Their thoughtful discussion of this paradox has implications well beyond this case study.

IRPP will be publishing a number of other studies as part of this research program. The authors will present case studies of innovations in public policies and programs in a given policy sector, including how the innovations were developed and implemented, and assess the results — including the impact on outcomes and lessons learned. The studies will be situated within a broader context, including historical and constitutional factors, and will outline policy directions for further progress within the policy field. It is hoped that, consistent with IRPP's mandate, this research will inform citizen understanding and policy-making in this important domain.

Cette publication représente une étape de plus dans le programme de recherche de l'IRPP sur la qualité de vie des Autochtones, qui comprend une série d'études consacrées aux innovations récentes apportées aux politiques et programmes publics ainsi qu'aux partenariats avec les Autochtones. Le programme de recherche s'inspire des travaux menés dans le cadre du projet de l'IRPP sur l'art de l'État, volume III, et en particulier des contributions d'Evelyn Peters, de Joyce Green et Ian Peach, et de John Richards à l'ouvrage *Belonging? Diversity, Recognition and Shared Citizenship in Canada*, publié par l'IRPP en 2007.

La situation d'un grand nombre d'Autochtones est l'une des questions les plus urgentes auxquelles doit s'attaquer la politique publique au Canada. Plusieurs indicateurs, depuis les niveaux de revenu et de chômage jusqu'aux indicateurs de santé, soulignent l'écart important qui existe entre de nombreux Autochtones et les non-Autochtones du point de vue des chances d'épanouissement. Certes, des progrès ont été enregistrés dans certains domaines — en ce qui a trait à la proportion des Autochtones qui ont achevé leurs études postsecondaires, par exemple. D'autres indicateurs, tel l'Indice de développement humain des Nations Unies, continuent néanmoins de mettre en lumière les disparités inacceptables qui

persistent entre Autochtones et non-Autochtones au Canada. Les ententes d'autonomie gouvernementale signées depuis une trentaine d'années, en particulier dans le Grand Nord, renferment la promesse d'une meilleure qualité de vie pour les Premières Nations qui ont pu acquérir leur autonomie communautaire, mais la majorité des Autochtones, en particulier ceux qui vivent en milieu urbain, ne sont pas présents dans ces accords. Dans leur cas, il faudra envisager d'autres formules et, surtout, faire preuve d'une volonté politique renouvelée.

Dans la présente étude, Bruce Minore et Mae Katt se penchent sur l'avènement de l'autodétermination des Autochtones dans l'important secteur de la politique publique que sont les soins de santé. Dans ce contexte, les auteurs définissent l'autodétermination comme étant la création, le maintien et le contrôle de services à la communauté en réponse aux besoins identifiés par cette dernière. Dans près des trois quarts des 599 communautés des Premières Nations et inuites où la politique actuelle permet à une certaine forme d'autodétermination de s'exercer dans le domaine de la santé, les services sont dispensés par des organismes contrôlés par les Autochtones. L'étude se concentre sur les équipes communautaires de gestion de crise mises sur pied par les Premières Nations Nishnawbe Aski dans le Nord de l'Ontario. Ces équipes, créées en réponse à une épidémie de suicides dans la région, sont financées dans le cadre de la Stratégie de ressourcement pour le mieux-être des Autochtones, une initiative issue d'un partenariat entre les Autochtones et le gouvernement ontarien. Les auteurs signalent que lorsqu'on a, dans le cadre de cette stratégie, standardisé les processus nécessaires à la gestion d'un ensemble diversifié de programmes à travers la province, cela a eu pour effet de réduire l'autonomie pourtant essentielle à la réalisation de ces programmes communautaires. La portée de leurs observations sur ce paradoxe déborde largement la présente étude de cas.

L'IRPP publiera plusieurs études additionnelles dans le cadre de ce programme de recherche. Les auteurs présenteront des études de cas axées sur les innovations apportées aux politiques et programmes publics dans des secteurs déterminés de la politique publique, signalant notamment comment ces innovations ont été élaborées et mises en œuvre, et analyseront les résultats de ces innovations, y compris leur impact sur la situation des Autochtones et les leçons tirées de ces expériences. Les études s'inscriront dans un contexte plus large, où seront notamment évoqués les facteurs historiques et constitutionnels, et proposeront des orientations destinées à améliorer davantage la situation dans ce secteur de la politique publique. On espère que, conformément au mandat de l'IRPP, ces études de recherche contribueront à une meilleure compréhension au sein de la population et à la prise de décisions dans ce domaine important.

About the Authors

Bruce Minore, Ph.D. (sociology), is research director at the Lakehead University site of the Centre for Rural and Northern Health Research (CRaNHR). For the past 17 years, Bruce and his colleagues have worked with Aboriginal community partners, as well as Health Canada and the Ontario Ministry of Health and Long-Term Care, on projects that have a direct policy/-program focus. These studies have looked at the delivery of care for specific conditions (mental health and cancer) or human resource issues (the recruitment of health professionals and the appropriate use of paraprofessionals). Most of this research has been done in northern Ontario, although the team recently finished two province-wide human resource studies on cultural competence in mental health and the preparation for practice in First Nation communities.

Mae Katt, RN (EC), ME.d., is a member of the Temagami First Nation on Bear Island and currently works as a nurse practitioner at an Aboriginal Health Access Centre in Thunder Bay. From 1996 to 2000, Mae was Ontario regional director for Health Canada's First Nations and Inuit Health Branch. Previously she was the health director for the Nishnawbe Aski Nation for six years, and she spent four years as the founding coordinator of the Native Nurses Entry Program at Lakehead University. She has a long history as an affiliated researcher at the CRaNHR, and has taken the lead on projects focusing on access to care for Aboriginal Ontarians, including an ongoing study for the Ontario Health Quality Council.

3

Contents

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Radical changes have occurred in the policies guiding and structuring the delivery of health care to Canada's Aboriginal people. These changes started almost 20 years ago, and their momentum has escalated over the past decade as the principle that Aboriginal people must develop, plan, manage and control their own health services has gained acceptance among decision-makers. It is now generally recognized that First Nations, Métis and Inuit people have unique knowledge that can make the services offered more culturally appropriate. This idea was embedded in the *Blueprint on Aboriginal Health*, jointly developed by the federal, provincial and territorial governments with representatives of Aboriginal peoples from across the country (Health Canada 2005a). Its incorporation reflected years of advocacy on the part of Aboriginal organizations and a considerable body of research. Indeed, the foundational review done for this IRPP research program on the quality of life of Canadian Aboriginal people, of which this paper is a part, concluded that the message from researchers and Aboriginal groups alike in reference to mental health was that "self-determination should be the mainstay, the fundamental premise of any policy aimed at mending Aboriginal quality of life" (Salée, Newhouse and Lévesque 2006, 18).

It is our position that self-determination *is* a necessary condition for the improvement of Aboriginal people's health — but it is not sufficient in itself. This is because the factors contributing to an effective transfer of responsibilities can become self-limiting, particularly when initiatives are on a large scale. Consider the fact that a principle indicator of successful transition is accountability to all stakeholders: clients, leaders and governments. But accountability frequently requires a high degree of standardization, which means that decision-makers, even though they are Aboriginal people, cannot always take local traditions and preferences into account. In other words, the development of self-determination in Aboriginal health is a story of considerable success, but one that

raises important caveats. And, as we will show, some things do not work out as intended on the front lines of health care.

In almost three-quarters of the 599 First Nations and Inuit communities where current policies permit some form of self-determination with respect to health, people are now served by Aboriginal-controlled organizations (Health Canada 2006, vol. 2). This has been accomplished principally through transfer, integration, self-government or land claims agreements between the federal government and First Nations or Inuit peoples. However, it is also usual and expected practice for provincial and territorial initiatives. Achieving this situation required extensive negotiations, and it had to be attained incrementally because of the complex jurisdictional, social and political environment involved. First Nations, Métis and Inuit peoples have distinct histories, rights, needs and legal relationships with the state; consequently, they have resisted attempts to create pan-Aboriginal approaches to health service delivery. Rather, the various groups have adopted distinction-based action plans. For example, the 2005 blueprint includes three separate tailor-made frameworks. Ontario's contribution to that national document offers the additional rationale that "no single approach to health will address or resolve the needs of all Aboriginal communities" because of profound differences in traditions, identity and residency (Ontario Ministry of Health and Long-Term Care 2005, 1).

While neither the legitimacy nor the potential benefits of Aboriginal self-determination in health matters are questioned, the approaches to realizing it have been subject to criticism. Aboriginal citizens bear a heavier burden of ill health than do most Canadians and, at the same time, their communities have access to fewer physical, financial and human resources. The word "crisis" is not uncommon in descriptions of both health status and resource deficits. These are also chronic, seemingly intractable problems. Consequently, some critics fear that government strategies that encourage communities to take control of their health actually amount to "abandonment in the guise of empowerment" (MacIntosh 2006, 208). But others might argue that while health disadvantages persist, the situation has improved; perhaps only modestly in terms of health outcomes, but significantly when cultural determinants of health are considered.

This paper examines the shift to self-determination that has occurred in Canada's Aboriginal health policies, focusing on their application to First Nations, particularly those in northern Ontario. Policies and programs vary in their particulars from province to province and between territories; but the underlying principles are essentially the same, as are many of the challenges and outcomes. We therefore believe that it is reasonable to draw on the experience of one province — Ontario, home to almost 20 percent of Canada's Aboriginal people — in exploring the effects of self-determination on the quality of life typically found in more remote parts of the country.

We provide an overview of the evolution in thinking and practice that occurred over a period of almost 40 years and summarize the results. To do so, we have had to examine developments at the federal level, especially the Aboriginal Health Transfer Policy, because federal initiatives set the stage for what has taken place provincially and territorially. However, provincial and territorial governments provide the majority of services to Aboriginal people; consequently, changes in provincial/territorial practices are of fundamental importance. Indeed, we use an extended case study from northern Ontario and involving a provincially supported initiative — community crisis teams in Nishnawbe-Aski First Nations settlements — to illustrate the strengths, weaknesses and paradoxes that emerge from the implementation of locally controlled health programs.

The observations and conclusions presented here are based on the findings of two pieces of research: an in-depth analysis of health care delivery in three remote First Nations communities where responsibility for services has been transferred to a local Aboriginal health authority (Minore et al. 2004); and data from the northwest region collected as part of a province-wide study of cultural competence in the provision of Aboriginal mental health services (Minore et al. 2007). The former study involved the review of 135 client charts and open-ended interviews with 30 community-based professional and paraprofessional health team members. The northwest data set for the latter study incorporates the views expressed by 35 individuals in open-ended interviews done in six First Nations communities and in the region's principal referral centres (Sioux Lookout, Kenora and Thunder Bay).

Both studies followed inductive procedures, whereby the volume of information collected was reduced by focusing on recurring concepts and their relationships with one anther (Patton 1990). The data was independently coded by each researcher; their results were then compared and consensually validated. Because we recognized that neither study was designed to address

the specific focus of this paper, we decided that in order to ensure that our interpretations were fair and accurate, we would conduct two supplementary interviews with individuals qualified to comment on the crisis team program.

Aboriginal Health Status

In his in-depth report on health care in Canada, Roy Romanow concluded, "The general health status of Aboriginal peoples is better today than it was 50 or even 10 years ago primarily because of noticeable improvements in living conditions and continued investment in disease prevention and public health" (2002, 218). Nonetheless, on virtually every indicator Aboriginal Canadians fare poorly relative to the population as a whole (Health Canada 2001; Young 2003). For example, a comparison of the Ontario First Nations Regional Health Survey and the Ontario part of the National Population Health Survey shows that the prevalence of reported chronic conditions is significantly higher among Aboriginal Ontarians (MacMillan et al. 2003).

Looking at disease after disease, study after study has drawn the same conclusion: Aboriginal people are more at risk of developing a serious health problem. The occurrence of non-insulin-dependent diabetes mellitus is three to five times higher than the Canadian norm (Macaulay et al. 2003); it has been diagnosed in First Nations children as young as five (Morrison and Dooley 1998). It is thus not surprising that cross-group studies show much higher rates of overweight and obese Aboriginal people (Tremblay et al. 2005). This group also compares unfavourably when risk factors linked to cardiovascular disease (like smoking) are considered (Anand et al. 2001). Adding to this litany of bad news, hypertension levels are higher among Aboriginal people (MacMillan et al. 2003). However, cancer rates in this group are still below the national average (Marrett and Chaudhry 2003) – probably due to the youthful demographic profile of Aboriginal communities. But survival rates are poorer, especially for those living in remote places, because patients tend to present only when their conditions are at an advanced stage (Lightfoot et al. 1996). In Ontario, for example, cancer is the third most frequent cause of death among Aboriginal people, after heart disease and violence or accidents.

The determinants of Aboriginal health are essentially the same as those for the general population (Wilson and Rosenberg 2002). The difference in morbidity rates simply testifies to the Aboriginal disadvantage with respect to most of these variables. For example, water supplies contaminated by raw sewage in many First Nations communities cause the bacterial infection shigellosis at almost 20 times the national rate (Adelson 2005). Overcrowded housing, both on- and off-reserve, is common (Canada Mortgage and Housing Corporation 1997); this contributes to the spread of infections diseases like tuberculosis (Clark, Riben and Nowgesic 2002). Of course, poverty influences housing choices, particularly for those living off-reserve. It also contributes to poor dietary choices. People opt for the type of high-fat, low-fibre diets that are cheaper but lead to diabetes and obesity (Gittelsohn et al. 1998). Choices in other areas also introduce significant health risks. Consider smoking; for example, 79 percent of males and 72 percent of females living on-reserve in Ontario report that they smoke compared with 30 and 27 percent, respectively, of the general population (MacMillan et al. 2003). At the same time, Aboriginal lung cancer rates are rising (Marrett and Chaudhry 2003).

No large-scale epidemiological studies have established the prevalence of mental health problems among Canada's Aboriginal people. However, a marginalized status combined with cultural oppression is thought to contribute to widely observed clinical deviations (Kirmayer, Simpson and Cargo 2003). Much of the blame has been placed on the residential school system, which has had long-term effects. The social and psychological trauma of the residential school experience is manifest in the form of "dissociation, mood, personality, or behaviour problems, alcohol or other substance abuse, self-harm and suicide" (Lederman 1999, 60). The intergenerational impact of the schools is an issue of compelling and continuing concern (Smith, Varcoe and Edwards 2005).

While there is an extensive body of literature about the health status of Canada's Aboriginal people, the coverage is far from comprehensive, or even adequate. Although certain populations – including the Cree and Ojibwa of northern Ontario – are the subject of numerous articles, comparatively little has been written about those who live off-reserve in rural areas and urban centres, or about the Métis and those who do not have registered status (Health Canada 2001). Some topics, like diabetes, are well researched, but others – including injury, a leading cause of

death – are largely ignored (Young 2003). To an overwhelming extent, the published material on Aboriginal health is deficit-oriented, focusing on problems, failures and negative comparisons (Reading and Nowgesic 2002). With a few exceptions (Migone and O'Neil 2005; Wilson and Rosenberg 2002), there is little in the way of strengths-based analysis, which would acknowledge the resilience and resourcefulness of the people and their cultures.

Canada's Aboriginal Health Care System

To understand the emergence of self-determination in the realm of health, it helps to answer two questions: "Who does what?" and "Who is responsible for what?" But the answers to the first are not always congruent with the answers to the second. Aboriginal people in Canada receive health care from a complicated and, at times, contested system of services provided through the federal and provincial or territorial governments, as well as through Aboriginal organizations (sometimes in partnership with one or other level of government). The system is complex because it derives from a mix of jurisdictional concerns, legal interpretations, policies and established practices. Perhaps the easiest way to cut through this Gordian knot is, first, to look at who does what in practice.

Who does what?

Although the federal government is often considered to have primary responsibility for Aboriginal health, the majority of services are in fact provided by either the provincial or territorial governments. Still, Health Canada does fund, and in many cases delivers, services to people who have status[1] and live on-reserve through five programs: community health services; environmental health and surveillance; the National Native Alcohol and Drug Abuse Program; hospital services; and capital construction. A sixth program involves noninsured benefits (so-called because they are not covered by provincial health plans); prescription medicines, dental care and eye care are covered for people with status, regardless of where they live. The federal government also provides services normally covered by provinces, such as physician care, in remote communities where they would not otherwise be available. Métis and other Aboriginal people who lack a status card have limited access to

federally supported health programs, except for some prevention and promotion efforts.

Of course, the federal government contributes substantially to supporting services offered by the provinces. The Canada Health Transfer provides cash and tax transfers to ensure that predictable and sustainable funding is available to give all Canadians access to health care, as mandated by the *Canada Health Act*. For their part, the provinces have constitutional and legislative obligations to provide health care for all residents. Indeed, most of the services that Aboriginal people (like other residents) access are those funded by the provinces – such as hospital care, physician or nurse practitioner services, home care, assistive device programs and ambulance services. However, documenting levels of utilization is difficult, because most data does not include the unique identifiers necessary to do so.

A parallel situation exists in the far north, where the three territorial governments have responsibilities with respect to health care that are similar to those of the provinces. Aboriginal people comprise a substantial part of each territory's population: 22.9 percent in the Yukon, 50.5 percent in the Northwest Territories and 85.2 percent in Nunavut (Statistics Canada 2001). Because the populations are small and widely dispersed – combined with the fact that funds, facilities and clinicians are limited – the territorial governments concentrate on delivering primary health care services. To meet the need for advanced-level care, they have entered into service agreements with various provincial governments. Although the particulars vary – for example, the Non-insured Health Benefits Program for First Nations and Inuit people is administered by the Northwest and Nunavut territorial governments, but it has been transferred to the control of Aboriginal communities in the Yukon – arrangements in the territories are quite equitable. Romanow concludes that "[i]n effect," the territories "have established a collective citizenship that emphasizes social solidarity for all groups and cultures, but, at the same time, respects the cultural and ethnic differences of their populations" (2002, 223).

Several provinces have designed programs specifically to meet the various health needs of their Aboriginal citizens – Ontario is one. The Aboriginal Healing and Wellness Strategy (AHWS), jointly managed by the province and Aboriginal organizations, involves a number of initiatives with a combined budget of about $38,000,000 per annum. These include a province-wide network of Aboriginal health access centres that provide community-based primary health care, crisis intervention teams that respond to suicide

incidents, translation services and medical hostels for those who require care outside their home communities. The provincial government, again in partnership with Aboriginal organizations, also mounts pathology-specific efforts, such as the Ontario Aboriginal Diabetes Strategy, or it provides designated funding within broader initiatives, like the Smoke-Free Ontario Strategy. Similarly, Cancer Care Ontario, with continuing guidance from Aboriginal stakeholders, has a unit dedicated to addressing cancer surveillance, awareness and programming needs within Aboriginal communities.

The partnership basis on which these Ontario programs function reflects the fundamental shift that has occurred across the country. But beyond such collaborative efforts, Aboriginal organizations now have sole or lead responsibility for health services delivery in many places. Land claims agreements, transfer or integration agreements, and self-government negotiations have created a situation in which most First Nations and some Inuit communities are able to take responsibility for the management of their local systems of health care. As a result, those in charge can tailor services to suit the priorities and resources of their communities, rather than accept one-size-fits-all programming from a central authority. This can alter the range and scope of the programs offered, mean greater involvement of Aboriginal providers and redirect accountability to local decision-makers.

Despite the trend toward Aboriginal control or, alternately, significant program input, Aboriginal health and well-being still gets caught on the invisible barbed wire that seems to mark jurisdictional perimeters. MacIntosh cites the example of the Grassy Narrows and White Dog reserves in northwestern Ontario, where mercury from nearby paper mills polluted the river system and contaminated the fish stock, a major source of food, causing severe health problems (2006). However, because their health was deemed a federal concern, while the province was mandated to protect the environment and regulate industry, people in these communities had to engage in a long and debilitating struggle to get their situation addressed. Such barriers are not uniquely an intergovernmental phenomenon. Even at the same level of government, Romanow notes, policy sectors function within silos (2002). So health is dealt with separately from the very social services (for example, education and housing) that are determinants of health. These divisions may be offset in some instances by interministerial initiatives on an issue,

but mandate protection and funding considerations continue to get in the way.

Who is responsible for what?

Just who has legal responsibility for the health and well-being of Canada's Aboriginal people, particularly those with status? Opinions differ, depending upon how one interprets legislation, policies and historic practices. The *Constitution Act, 1867* makes the federal government responsible for those who at the time were referred to as "Indians" and the lands reserved for them, while putting health in the hands of the provinces. Moreover, section 88 of the *Indian Act* stipulates that generally applicable provincial laws (which logically would include those pertaining to health) also apply to Indians. Subsequent court decisions have held that health might be subject to either federal or provincial legislation, depending on the particulars of the matter addressed. MacIntosh sums up the situation thus: "In a nutshell, the issue is whether Aboriginal health governance is properly characterized as (1) an 'Indian' matter, and so within federal jurisdiction, (2) a 'health' matter, and so within provincial jurisdiction, or (3) a federal incursion into provincial jurisdiction which must be legitimated on a case-by-case basis" (2006, 196). This legal uncertainty has led not only to intransigence and conflict at times but also to the exclusion of nonstatus individuals from benefits enjoyed by those with status.

For its part, the federal government takes the position that it has no constitutional or treaty obligation to provide health care to any Aboriginal people, although it voluntarily does so in instances where the services would not otherwise be available (Health and Welfare Canada 1974). In this regard, Ottawa acts on the basis of long-standing practice rather than statute. However, the Royal Commission on Aboriginal Peoples argued that the trustee role of the federal government set out in various treaties and the *Constitution Act* is made manifest through existing federal health programs (1996). Meanwhile, after years of foot-dragging, provincial governments have accepted that they have legal obligations to their Aboriginal citizens that extend beyond making health services available to all residents. Turning again to the Ontario case, this position is reflected in a recent policy document, *Ontario's New Approach to Aboriginal Affairs*, which outlines a number of initiatives undertaken on- and off-reserve in partnership with Aboriginal groups (Ontario Native Affairs Secretariat 2005).

The involvement of various levels of government – federal, provincial, territorial, Aboriginal – creates a complex, uncoordinated system characterized by gaps in service and overlapping coverage. It also results in funding duplication and anomalies. Obviously, the status factor alone denies some Aboriginal people access to supports available to others. But disparities can cause discontent that potentially affects services too. For example, nurses employed by First Nations communities may be paid less than their counterparts in neighbouring communities who are employed to do the same type of work by the First Nations and Inuit Health Branch. This simply reflects the fact that federally employed nurses have received incremental pay increases to match those in the broader nursing job market, whereas agreements transferring responsibilities to communities do not provide for staffing or other cost increases. The sum of money available is set at the time of signing and is largely based on the amount then being spent on services; it remains fixed for the duration of the agreement, unless across-the-board adjustments are made.

Because much of the funding comes from program-specific envelopes, there are different lines of accountability, and each program has its own purpose-designed format for processing information. This generates a great deal of time-consuming paperwork at the local level, which is a source of constant complaint. Much of the funding is provided on a short-term basis. With annualized payments, there is no assurance that an initiative will continue past the fiscal year-end, which makes it difficult to attract and keep good staff. Strategic funding also tends to be proposal-driven, compelling communities to make a case for new and renewed monies. This, of course, adds to the administrative burden and situational uncertainty (Ontario Health Quality Council 2007) – hence the call for program and capital funding that is "stable and sustainable, long-term and appropriate to regional realities" (Health Canada 2005a, 6).

Transferring Control of Aboriginal Health: From Idea to Ideal

In 1989, the federal government put into place mechanisms whereby those First Nations and Inuit people who wished to do so could assume control of their own health care services. At the time,

it was thought that this might eventually lead the federal government to turn out the lights in the Health Canada offices, where the management function had long resided – a notion now recognized as a misjudgment. The government's role would not disappear, but it would change to one of guidance, consultation and support. This profound shift was the fruit of 20 years of thinking about Aboriginal health. And, while it marked a critical transition, it was not the end point on that policy continuum.[2]

It started in 1969, when Minister of Indian Affairs Jean Chrétien released *Statement of the Government of Canada on Indian Policy*; such discussion documents are referred to as White Papers, and the shorthand reference for this highly controversial one quickly became "the 1969 White Paper." In it, the government proposed to discard the *Indian Act*, and with it such concepts as status and the right to separate health services. The provinces would take responsibility for providing health services for Aboriginal people, just as they did for any citizen. Negative reaction to these proposals was swift. In 1970, the National Indian Brotherhood's Alberta chapter released "Citizens Plus," quickly dubbed the "Red Paper," which stressed both the federal government's obligations with respect to health care and the need for First Nations peoples to control what was happening on their lands, including the delivery of government services. Faced with widespread protest, the Trudeau government withdrew the 1969 White Paper later that year. However, the heated debate sparked a significant rethinking of Canada's approach to Aboriginal health. It also forced the government of the day to realize that unilateral moves were unacceptable – it would have to consult with and listen to those affected by policy changes.

The emergence of a new attitude was evident in 1975, when a paper entitled "The Canadian Government/The Canadian Indian Relationships" was released. It provided a framework that enabled First Nations communities to take responsibility for delivering specific services through such programs as the Community Health Representatives and the National Native Alcohol and Drug Abuse Program. These major initiatives are still in operation today, albeit in a somewhat modified form. Both supported paraprofessional workers – individuals from the communities with cultural knowledge and language skills who were specially trained to conduct therapeutic interventions and provide health promotion services. Transferring control of two such essential programs signalled the direction that the federal government was prepared to take.

The government's new approach was manifested more broadly in 1979, with the adoption of the Indian Health Policy. Explicitly acknowledging the living conditions that contributed to poor health for many First Nations people, the policy sought "to achieve an increased level of health in Indian communities generated and maintained by the Indian communities themselves" (Health Canada 2005b, 2). This state could be achieved only by recognizing three fundamentals: the need for community development to overcome the conditions detrimental to well-being; the need to sustain the trust on which the special relationship between the federal government and First Nations communities was founded; and the need to maintain the federal government's role with respect to Aboriginal people's health within the larger Canadian health system. Perhaps of greatest importance, however, was the policy's affirmation of the concept of community control.

A series of events in the 1980s led Aboriginal people to recover their voices in matters affecting them. First, in 1980, the *Report of the Advisory Committee on Indian and Inuit Health Consultation* — the Berger Report — appeared; it outlined the essential elements for meaningful consultation with Aboriginal people. Then, in 1983, the *Report of the Special Committee on Indian Self-Government* was issued, and the document lent credence to the idea that First Nations and Inuit peoples had an inherent right to self-government; it specifically cited health as a domain where that right should apply. This aspiration was realized in 1986, when British Columbia's Sechelt Indian band became the first to sign a self-government agreement that, among other things, allowed them to take responsibility for the management and delivery of their own health and social services. Meanwhile, between 1983 and 1986, various First Nations communities, with support from the federal government, undertook a number of pilot community health projects to test the feasibility of a wide-scale health transfer.

Finally, the federal government approved the policy framework entitled Transfer of Health Programs to Indian Control (actualized by the Treasury Board in 1989). This enabled interested First Nations communities south of the 60th parallel to assume control of their health services. Beyond delivering mandatory public health and treatment programs, they would be able to customize or design programs to suit their needs and have the flexibility to allocate funds to address their priorities. Although total transfer was the only option at first, an alternative was eventually adopted for communities that wanted some measure of control but were not yet ready to assume full responsibility for delivering services. Known as the integrated approach, this measure allowed communities a degree of autonomy over community-based services but still obliged them to adhere to a negotiated work plan. Any changes required approval of Health Canada's First Nations and Inuit Health Branch. Agreements with respect to universal health services in the area north of 60 were made with the territorial governments in consultation with the affected Inuit and First Nations peoples. Yukon First Nations communities can undertake separate integration agreements, but transfer applies only to communities south of the 60th parallel.

Of the 599 eligible First Nations and Inuit communities, 47.4 percent have transfer agreements, 25 percent have integrated agreements and 0.8 percent are self-governing. So, in almost three-quarters of the places where some form of self-determination with respect to health is possible, people are being served by locally controlled organizations. Not surprisingly, the majority of the communities with transfer agreements are found in the southernmost regions, where there tends to be more developed capacity and greater access to resources, both financial and human. Nonetheless, more isolated communities account for about 30 percent of the total (Health Canada 2006, vol. 2).

As Health Canada reported, "As the uptake of control of health services by First Nations increased, the Indian Health Transfer Policy began to be seen increasingly by First Nations people as a stepping stone towards the inherent right of Self-Government" (2005b, 2). Indeed, the federal government's 1995 policy statement "Inherent Right to Self-Government" introduced a further option for communities wanting to control their own affairs, including health care. Without doubt, it is the most flexible approach. Under the self-governance model, bands are not bound to existing federal health programs but are free to create new programs to meet the demands of their members. Moreover, these programs and the assets they can include are more extensive than those covered by the usual transfer agreements (for example, treatment facilities on-reserve and services that are part of the Non-insured Health Benefits Program).

A 1998 policy created the possibility for First Nations and Inuit organizations to take control of secondary (zone) and tertiary (regional) services as well. To do so, they must first obtain the approval of each

and every community served by a specific program and prove that they are capable of delivering the mandated services. Similarly, mechanisms exist for the administrative transfer of federal hospitals and non-medical residential treatment programs to incorporated governing bodies for the respective facilities.

A comprehensive national evaluation of the transfer policy, undertaken for Health Canada by the Manitoba-based Centre for Aboriginal Health Research, concluded that the outcomes are generally good: "First Nations and Inuit organizations have thrived as a result; service responsiveness has improved; mandatory programs are being delivered; and the accountability of Chief and Council in health matters has improved from pre-transfer times" (Health Canada 2006, vol. 1:24). The latter finding is of striking importance. In an earlier study, conducted in northern Ontario, local leaders were criticized for not paying regular attention to the mental health issues affecting youth in their communities because they were caught up in the broader constitutional concerns of the day (Minore, Boone, Katt and Kinch 1991). However, despite the overall positive reviews, implementation of the policy has given rise to certain anomalies that have the potential to undermine the larger objectives.

First among these are anomalies related to funding. The monies available to a given community are partly dictated by precedent — by how much was being spent on services at the time of transfer — regardless of changing needs, capacity building or demographic growth. Over time, inequities linked to the date of transfer have arisen: for example, the salaries of community employees, such as those who work within the Community Health Worker Program and the National Native Alcohol and Drug Abuse Program, can vary from community to community. A significant portion of the available funds is used for health-issue-specific purposes and cannot be redirected to meet other, more pressing needs. As yet, the system has not produced a mechanism though which these variations and instances of underfunding can be addressed. Moreover, the communities manage targeted, time-limited programs that do not fall under their transfer agreements. The net result is a mix of contractual obligations, each with its own reporting requirements. Naturally, accounting in a timely manner for monies spent is an ongoing task, and that task is more difficult when it is necessary to document goal-linked outcomes. This accounting constitutes a heavy administrative load, which staff can carry only if they cut down on other activities — like the program planning that is vital in the face of continuously changing priorities.

Romanow notes that "funding can be transferred, but it is difficult to transfer knowledge and experience in addressing a variety of health care issues 'on the ground'" (2002, 214). Obviously, communities vary in their initial ability to take over the administration, planning and delivery of health care services. And, since these functions are generally performed by relatively few individuals, the capacity going forward fluctuates as staff turn over. Stability requires investment in maintaining and building the communities' health human resources capabilities through continuing education. But this often does not get the attention it warrants — certainly, the issue is recognized as important, but more immediate needs compete for scarce resources.

A second by-product of implementing transfer, integration and self-government agreements is uncertainty over the role now played by the First Nations and Inuit Health Branch. On one hand, Health Canada bureaucrats see it as one of monitoring and making sure that mandatory public health services are delivered; on the other hand, they view it as an advisory role (Health Canada 2006, vol. 2). At times, this must prove inherently contradictory. In instances of perceived noncompliance, the monitoring function trumps the advisory one, enabling the government to step in and take corrective action if it sees fit.

Taking Control in a Crisis: A Northern Ontario Case Study

The evolution in thinking about Aboriginal health and the changes in policies and legislation that made self-determination possible took place over an extended period. The effects were national — or, at least, provincial/territorial — in scope. But frequently these large-scale changes were pushed forward by local or regional occurrences. For example, a suicide crisis in northern Ontario in the late 1980s compelled the region's First Nations leaders to act decisively and independently to exploit (in the best sense of the word) a growing consensus that Aboriginal people should have a voice in decisions affecting their health and well-being. In the ensuing years, experience with self-determination accumulated and ideas about it changed.

In remote communities across Canada's north, the suicide of a young person is a tragically frequent occurrence. In parts of northern Ontario, it started happening suddenly, in 1986. Within seven years, 129 youths from 49 small First Nations communities had died by their own hand, and hundreds of others had attempted to kill themselves. In 1993, the chiefs of these communities — collectively called the Nishnawbe-Aski First Nations — launched an inquiry, led by a group of youths, to examine the causes and make recommendations about how the communities and their leaders could deal with the crisis. The Nishnawbe-Aski Nation Youth Forum on Suicide spent three years exhaustively examining the issue through a series of public and private hearings in the communities. These hearings gave residents, especially young ones, an opportunity to talk about the quality of their lives and the nature of their experience. The youth forum was a massive undertaking — and an early example of Aboriginal people setting a course for themselves, independent of outside forces. Although the federal and provincial governments contributed funding for the initiative, it was designed and managed entirely by the Nishnawbe Aski Nation (NAN), the nonprofit corporation established by the region's chiefs to represent their communities' health, social welfare, education and legal interests.

The Cree and Ojibwa communities encompassed by the NAN are scattered over a vast stretch of subarctic boreal forest extending more than 1,100 kilometres north from the 50th parallel to the Hudson's Bay coast, and approximately 645 kilometres west from Quebec to the Manitoba border. The area comprises about 60 percent of Ontario's land mass. The most recent data available show that 24,827 people live in the region; fewer than 30 reside in the smallest settlements, but more than 1,850 live in the largest (Timpson and Ross 2004). Most of these settlements can only be reached by airplane or, during the winter, by ice roads cleared over frozen lakes and rivers. In terms of their size and remoteness, Nishnawbe-Aski First Nations settlements typify those Aboriginal communities found in northern parts of the provinces and the territories.

Despite the expanse of unoccupied land surrounding their communities, the Nishnawbek live in close proximity to one another, crowded into small, prefabricated, poorly insulated houses that often lack basic amenities — even indoor plumbing. Their living conditions give rise to a high incidence of contagious diseases like pneumonia, tuberculosis and gastroenteritis.

Moreover, the people are heavily burdened by chronic conditions, especially diabetes, heart disease and, increasingly, cancer. Severe trauma resulting from accidents and violence is common. And the communities are plagued by alcohol and substance abuse; for example, adolescents sniff glue and gas fumes for a short-lived high that can cause permanent brain damage. Only essential primary health care is available locally, administered by resident nurses and paraprofessionals or by physicians on monthly visits. For the most part, these services are still provided by the federal government, since only a few of the region's communities have entered into transfer agreements. To access tertiary care, band members must travel south to a regional centre like Timmins, Sioux Lookout or Thunder Bay. At times, the demand-supply equation with respect to health care is thrown seriously off-balance. And when a health care system is stretched to the point where it must function largely without backup, those suffering from mental disorders are placed in particular jeopardy.

The communities are not all alike. Some are cohesive and well organized, while others are marked by internal conflict and disorder. Some follow traditional ways; others embrace modern advances. Some are dominated by religious groups; others are not. Some are politically stable, but others experience frequent and acrimonious leadership changes. No matter what circumstances they find themselves in, most Nishnawbek seem to accept their situation stoically, turning inward for solutions. Still, a few statistics underscore the harsh realities the Nishnawbek face and the resulting self-destructive tendency among their young: 65 percent of the population is younger than 26; the majority have less than a grade-nine-level education; the unemployment rate sometimes exceeds 90 percent, and, with the decline of traditional pursuits like fur trapping, various forms of social assistance have become the main source of income. "It almost seems like a recipe for suicide: the convergence of youth living in isolation, without education, without jobs, without much to do — and without hope" (Katt et al. 1998, 216).

Such was the environment in which the youth forum began its work. Recognizing the emotionally charged nature of the forum's mandate, a team of experienced mental health counsellors and elders put a great deal of effort into preparing for each site visit. The resident health teams were specially trained to support individuals through the stressful experience of testifying and through the emotional breakdowns triggered by painful

revelations. The commissioners, two youths and one adult on each panel, also received extensive training in how to handle disclosures and manage the stress and anger exhibited by some of those appearing before them. Advance teams spent about two weeks prior to the hearings explaining the process to community members, responding to their questions and attempting to allay their concerns. The hearings themselves took a week on average, and they were followed up by visits from mental health specialists.

The youth forum found that a complex set of factors was contributing to the self-inflicted carnage. These factors included a host of personal traumas. In some cases, there had been physical or sexual abuse; in others, the loss of a loved one. But there were causes rooted in communal practices, too. For instance, the opinions of the young were not welcomed or respected in the more traditional, elder-dominated communities; young people felt silenced and undervalued. As well, there were systemic issues — the consigning of children to residential schools in the past, and the ongoing Child and Family Services practice of taking children into care, which was seen as unjustified in some cases. It was clear that there would be no easy remedies.

However, in their final report, *Horizons of Hope: An Empowering Journey*, the commissioners made a total of 50 recommendations, which they divided into packages targeted on specific groups: community leaders, communities as a whole, political leaders, youth, elders and adults (Nishnawbe-Aski Nation Youth Forum on Suicide 1996). The NAN established the Chiefs Task Force on Suicide in 1997 to work toward implementing the recommendations — a daunting task. But the overwhelming scope of the Task Force's mandate quickly led to a decision to focus on a few high-risk communities and specific programs. The Nishnawbe-Aski Nation Crisis Team program, a concept promoted by the forum, is one example of the latter.

After three deaths in Kingfisher Lake in 1987, a large group of people from neighbouring Muskrat Dam arrived to help community members through their immediate grief. Inspired by that event, the communities developed what came to be known as Helping Hands, a project to organize supportive visits at times of crisis. Albeit initially a somewhat haphazard effort mounted by untrained volunteers, Helping Hands quickly became a fundamental part of the communities' response to the growing crisis in their midst. However, it was soon clear that the process needed to be formalized to ensure that those involved were able to do what was expected of them. Nodin Counselling Services, an Aboriginal mental health program in Sioux Lookout, came on board to help with training; and the First Nations and Inuit Health Branch began underwriting the cost of chartering planes to transport volunteer crisis teams quickly to where they were needed. At the time, this funding was seen as discretionary — a crisis intervention measure rather than an ongoing commitment on the part of the federal government.

Implementation of the 1994 Aboriginal Healing and Wellness Strategy (AHWS), comanaged by Aboriginal organizations and the province, created an opportunity for the NAN chiefs to apply for a grant to fund community crisis teams on a continuing basis. Through the NAN (which is accountable to AHWS), the funds are allocated according to a formula that takes into account a community's size and remoteness. This permits every community to hire a coordinator — on a full- or part-time basis, depending on the amount of money available and the expected workload. The cost of vital equipment (like walkie-talkies) and training (in, for example, first aid and CPR) may be covered by the AHWS money also, although such things are often financed through community fundraising activities.

Over time, the role of the teams has expanded to cover many types of emergencies. They engage in search and rescue efforts and flood and forest fire evacuations; they deal with house fires and fatal accidents; they offer victim support and work drug patrols. And, of course, they continue to help communities cope with suicide. The composition of the teams varies, as does their expertise. They work regularly in their home communities, but they are also on call to travel where they are needed. As many as 65 travelling teams have been dispatched from one community to another in a single year. This level of activity may seem surprising, since each community has it own team. But when tragedy occurs, members of the affected community's crisis team will know the victim and may even be related to that person. Under the circumstances, if local team members are too traumatized to provide assistance themselves, they will call in another team. One person we interviewed also explained that the local team "may ask for young people who can provide high-risk monitoring or who can patrol because they are physically fit, or they may ask for elders, depending on what that team may be doing." Moreover, the special skills of individuals are widely known across the region, as are the unique competencies of particular teams. Deciding how best to respond to requests for team services is up to the local chief and council.

In some instances, the First Nations and Inuit Health Branch will fund the travelling teams. This happens less often now than it used to, but the need for such support has not changed. Some communities still ask outsiders for help and pay from their own resources, thus straining their budgets, but others have found creative ways to establish contingency funds. In Cat Lake, for example, where about 55 percent of the adult population is employed, $10 is deducted from the paycheque of each working person for the so-called Hope Fund. This money is used for various purposes, including bringing in crisis teams with particular expertise (Timpson and Ross 2004).

Given the small population base, the number of individuals involved is impressive. At last count, some 614 people were members of various crisis teams region-wide. The aim is to have teams of at least five people, but larger communities may have upwards of fifty people on whom they can call. Travelling teams tend to be composed of nine people, a number largely dictated by how many seats are generally available on outbound planes. Maintaining the volunteer pool is a challenge, however. Burnout is an important factor. The physical and emotional demands of the situations the teams face cause team members to disengage. One factor influencing the number of band members willing to join teams is the personality and reputation of the team coordinator. An interviewee thought that this actually accounted for much of the difference in recruitment from one community to the next: "sometimes you've got really good leaders in the crisis team coordinator position who welcome others and know how to support them," while other times there are "bad feelings, not a good working relationship." Team members are also regularly lost to band council service — in the past year alone, six active community crisis team members were elected as chiefs of various Nishnawbe-Aski First Nations communities.

Governance issues are evident at the local and regional levels, but many of them are put on the provincial table first. For example, until 2004 there was funding for the equivalent of 32 full-time workers, which was split among all the communities based on population. Some of the very small communities made do without a paid coordinator because their share of the money was not sufficient and the workload did not warrant even a part-time person. Then the NAN lobbied successfully for a funding increase to the equivalent of 47 positions. However, this brought with it an absolute require-ment that the money be allocated to pay a coordinator in all communities, effectively undercutting local-level flexibility, which had been a hallmark of the program. Of course, paying some people to do what others do voluntarily also creates a degree of tension. It was for this reason, before the must-pay-one policy was put in place, that the chief and council in one large community refused to pay one person alone; instead, they paid honoraria to all crisis team members.

The new expectation that every community will have a paid coordinator is considered to be a result of the adoption of a sophisticated electronic data-collection system, which is part of the AHWS commitment to accountability. This means that the individuals hired must be computer-literate; this is desirable, perhaps, but hardly the most critical skill for an intervention team leader to have. It also assumes a higher level of education than most residents have attained; again, formal schooling is not really necessary to take charge in a critical incident. Basically, the taken-for-granted skill sets possessed by many southern Ontario First Nations members are not generally found in the remote north. One person we interviewed said that AHWS sees compliance as "a matter of choice. If you are not complying it's because you don't want to, rather than it's difficult to." This underscores a wider dilemma. The fact that Aboriginal people are making the decisions is not sufficient. Although they may be sensitive to cultural issues and strive to appreciate the circumstance in which others live, they must still be able to understand real situational differences. In the north, the perception is that the decision-making is southern-dominated, albeit Aboriginal.

The data imperative is understandable, to an extent. To justify the need for continued funding one must show evidence of the effectiveness of the programs supported. But this becomes problematic when efforts are made to quantify what is, essentially, social interaction — which is mostly what the crisis teams do. "Their client is not somebody that is walking into the office [for a specific treatment]; it's somebody they've picked up on the road that looks like they've been sniffing," an interviewee said. Moreover, cause-and-effect relationships are impossible to demonstrate. Suicide and family violence are complex phenomena — far too complex to prove conclusively that crisis teams have had any impact on the rate at which they occur. Team members deal with situations. They may save a life, but they cannot solve the unemployment,

poverty, overcrowded housing or other factors contributing to peoples' distress.

Local-level expectations increasingly conflict with those that exist on the provincial level when it comes to the role of crisis teams. Take search and rescue as an example. The Ontario Provincial Police are mandated to take the lead in such cases; however, their involvement normally does not extend beyond a maximum period of 15 days. But the crisis teams, led by a paid coordinator, continue the search. Increasingly, such practices are being challenged at the provincial level because search and rescue is the police's job, not the job of the crisis teams, especially their paid members. Similarly, Indian and Northern Affairs Canada is responsible in the case of floods, and the Ontario Ministry of Natural Resources is responsible when there is a forest fire. From a bean-counter's perspective, this means that paid crisis team members should not be involved, unless they are acting in a volunteer capacity. In other words, the segregation of responsibilities characteristic of urban emergency services is increasingly being used as the standard against which the appropriateness of crisis team activities is judged.

In sum, the NAN crisis teams are a real example of self-determination. Evolving from a grassroots response to communities' crises, they were shaped by on-the-spot experiences or dictated by local priorities. They were endorsed by the Aboriginal-controlled Youth Forum on Suicide and embraced by the communities. And when stable funding came, it was through AHWS, a joint Aboriginal-Ontario initiative that emphasizes support for "community-designed and delivered programming" (Aboriginal Healing and Wellness Strategy 2007). While First Nations communities enjoy considerable flexibility on crisis team spending decisions, the program is administered by an Aboriginal organization (the NAN), which, in turn, is accountable to AHWS. The latter link introduces some tension. Still, as an almost pure example of Aboriginal control, the teams illustrate the strengths, weaknesses and paradoxes of Aboriginal self-determination.

Experiencing Aboriginal Self-Determination in Practice: Some Lessons

It has been more than a decade since the Youth Forum on Suicide made its report. The chiefs seized on its recommendations and acted where

immediate action was possible. But the crisis did not abate. From 1986 to the time of writing, 349 lives were lost and in excess of 4,000 suicide attempts were made (staggering occurrence rates, given the small population). The former number, sadly, is exact; the latter is less so, because some accidents are masked suicide attempts. There is a lesson in these statistics, although it is one the reader may think too obvious to merit articulating. Nonetheless, the notion of Aboriginal self-determination is sometimes offered as a blanket solution to the health problems First Nations, Métis and Inuit peoples face. And, indeed, it is an essential ingredient, but not a panacea. This is apparent when one considers the young people who have killed themselves in northern Ontario over the past two decades. After all, over that long period, the interventions attempted have been almost exclusively under First Nations control. As with most of the health challenges confronting Aboriginal people, there is no single-note response to suicide.

The case described offers a number of other lessons. The wide-scale embrace of Aboriginal self-determination in health has required that appropriate structures be put into place to manage programs, distribute funding in a transparent manner and ensure accountability throughout the process. It has demanded, in a word, a bureaucracy. And that word fairly describes Ontario's Aboriginal Healing and Wellness Strategy, with its multiplicity of programs and multimillion-dollar budget. Of course, efficient functioning in such an environment creates certain imperatives. One such imperative is hard data on activities undertaken within a program (although the numeric values requested may not reflect what actually takes place and may therefore be impossible to generate). At one recent point, it was implied that the NAN's inability to supply requested data could jeopardize crisis team funding. Such disconnects are not unique; they are a by-product of the type of decision-making endemic to bureaucracies. The fact that Aboriginal people are in control – while it undoubtedly helps to ensure that decisions are culturally appropriate – does not mean that they will always take into account all of the unique features of a given situation.

Bureaucratization inevitably curbs flexibility, a quality essential to local self-determination. Communities do not have the luxury of acting solely on their own priorities – they must function within constraints imposed from outside. In this case, the new requirement that all crisis teams have a paid coordinator, while acceptable to many communities, is at odds with chief and council preferences in some Nishnawbe-Aski First Nations settlements. Having

functioned fairly autonomously for almost a decade, communities now find it difficult to adjust to new expectations. This gives rise to tension, which will continue at least for the near term. Federal funding for travelling crisis teams is another example: limiting the support has not meant limiting the demand. Certain communities are coping with the shortfall by doing their own fundraising, but others are being forced into deficit positions.

The NAN's community crisis teams are in a state of flux, seemingly caught in an administrative transition. On one hand, key decisions have been made, and continue to be made, at the community level. For example, the person who fills the coordinator's position is chosen by the chief and council. It is up to the chief and council to evaluate the coordinator's job performance. In selecting that individual, they apply their own set of criteria, which may or may not take into account the expectations of the external funders. The successful applicant may or may not have the computer skills necessary to keep the database up to date — either way, the decision belongs to the communities' leaders. On the other hand, decisions made at the provincial table either challenge or confound those made at the local level. The reported challenges have to do with the nature of the tasks undertaken by paid team members. To suggest that paid members provide only mandated services, leaving other jobs to the police or specialist agencies, is to ignore the reality of life in very small communities, where such services are limited or must be delivered from a distance. Similarly, the ideal skill set for paid workers is not necessarily a good fit with the people available on the ground or the tasks they face.

It is paradoxical, but the success of Aboriginal self-determination can become its limitation. In this Ontario case, the Aboriginal Healing and Wellness Strategy has standardized and streamlined its processes to effectively manage a diverse group of programs province-wide. But in doing so, it may have curtailed some of the local autonomy that is the fundamental strength of the community-based programs it supports.

Conclusion

Over a comparatively short period, and at an escalating pace, self-determination has become the defining characteristic of Aboriginal-specific health policies and, to some extent, practices in Canada. This has occurred against a backdrop of improving, but still very poor health status among our First Nations, Métis and Inuit citizens, whether they live in urban centres, in rural communities or on reserve lands. Few would question that self-determination is a necessary condition for the continuing improvement of Aboriginal people's health. But actualizing this ideal in real situations is a complex process, and it may not play out as expected.

Our case study from northern Ontario illustrates this point. It highlights an ambitous, well-established provincial strategy that has given Aboriginal people a deciding voice in the way health services are provided to them. This strategy oversees a large number of initiatives across Ontario and administers a great deal of money. In such a situation, bureaucratization is inevitable, but accountability is vital, so bureaucrats make decisions that reflect their accountability to all stakeholders: clients, leaders and funders. As a result, measures are adopted that standardize procedures, taking a degree of freedom away from the communities that administer individual programs. This creates tension. Based on the principles of self-determination, as well as on previous experience, communities likely expect a high degree of autonomy. However, in some instances, the locals are forced to bend to new rules and procedures.

Hence a paradox: there is less local control over certain matters within a system founded on the ideal of local control. The case study demonstrates two reactions to external pressures: resistance in some communities; accommodation in others. The latter reaction may suggest a way out of the paradox. After all, programming changes will and must occur; if not, services and delivery systems will ossify and the flexibility vital to self-determination will be lost. A key factor in the process of change is the contagion of ideas. As they spread from one community to the next, some ideas will be early adoptions while others will lag behind — but changes will eventually take place. In this particular case, the reliance on crisis teams from neighbouring communities testifies to the extent

of interaction and sharing that occurs among Nishnawbe-Aski First Nations communities. We believe that similar exchanges are an integral part of the lives of Aboriginal people in all parts of Canada, and that they are the means through which self-determination is tailored, adjusted and made to work in the realm of Aboriginal health.

Self-determination alone can have little effect on most of the factors that define health status, however. Poverty, environmental contamination, inadequate housing and sanitation, or even lifestyle choices are not going to change because Aboriginal people are taking control of their health care — at least, not in the foreseeable future. However, one determinant can be affected immediately: culture. Where Aboriginal people control health programming, they are able to create clinical environments or provide nonclinical services in ways that acknowledge, welcome and celebrate clients' Aboriginal heritage. In time, perhaps, these attitudes will also prevail in the non-Aboriginal settings where Aboriginal people receive a lot of their health care.

Notes

1 The *Indian Act* identifies a person as having status if they are recorded in the Indian Register. Individuals of Indian ancestry who were not enrolled or who were removed due to the enfranchisement provisions of the Act are referred to as "nonstatus Indians."

2 Health Canada's *Ten Years of Health Transfer: First Nations and Inuit Control* provides a succinct summary of the history (2005b).

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Studies Published/Études publiées

"Aboriginal Women's Community Economic Development:
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Isobel Findlay, Wanda Wuttunee
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"Quality of Life of Aboriginal People in Canada: An Analysis of
Current Research"
Daniel Salée, with the assistance of David Newhouse and
Carole Lévesque
IRPP Choices, Vol. 12, no. 6 (November 2006)

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Aboriginal Health Care in Northern Ontario
Impacts of Self-Determination and Culture
Bruce Minore and Mae Katt

L'autodétermination est devenue un élément central des politiques et, dans une certaine mesure, des pratiques mises en place pour répondre aux besoins des Autochtones du Canada en matière de santé. Cette évolution s'est produite en relativement peu de temps et à un rythme de plus en plus rapide, alors même que s'améliorait l'état de santé des gens des Premières Nations, des Métis et des Inuits, qu'ils vivent en milieu urbain ou rural ou dans les réserves autochtones — un état de santé qui n'en reste pas moins très inférieur à la norme. La plupart des observateurs conviennent que l'autodétermination est une condition nécessaire à la poursuite de cette amélioration, mais sa concrétisation constitue un processus complexe et pourrait ne pas s'accomplir conformément aux attentes, tout au moins à court terme.

Les soins de santé que reçoivent les Autochtones du Canada leur sont dispensés au moyen d'un système de services fournis par le gouvernement fédéral et par les gouvernements des provinces ou des territoires, ainsi que par les organismes autochtones. Ce système compliqué repose sur un ensemble de préoccupations d'ordre juridictionnel, d'interprétations juridiques, de politiques diverses et de pratiques établies. Pour restituer le contexte permettant de comprendre comment s'est produit ce passage à l'autodétermination dans le domaine de la santé des Autochtones, notre étude répond d'abord à deux questions : Qui sont les principaux acteurs et que font-ils ? Quelles sont les responsabilités de chacun?

Nous présentons ensuite un aperçu de l'évolution des préoccupations au sujet du rôle des Autochtones en ce qui a trait à la maîtrise de leurs propres systèmes de santé, et décrivons les mesures prises pour assumer ce rôle. L'analyse porte principalement sur le déroulement des événements à l'échelon fédéral, en particulier sur la politique relative au transfert du contrôle des programmes de santé aux Autochtones, car ces initiatives ont préparé la voie aux développements qui se sont produits dans les provinces et les territoires. Ce sont toutefois les gouvernements provinciaux et territoriaux qui fournissent la majorité des services aux Autochtones. Le pro-

fil particulier des politiques et des programmes varie d'une province et d'un territoire à l'autre, mais les principes qui les animent sont essentiellement les mêmes, tout comme, d'ailleurs, les difficultés rencontrées et les résultats obtenus. C'est pourquoi nous nous servons de l'exemple de l'Ontario, où habitent près de 20 p. 100 des Autochtones canadiens, pour étudier les effets de l'autodétermination sur la qualité de vie qu'on trouve habituellement dans les régions plus éloignées du pays.

Pour illustrer les points forts, les faiblesses et les paradoxes qui se dégagent de la mise en œuvre de programmes de santé contrôlés au niveau local, nous faisons appel à une étude de cas détaillée menée dans le Nord de l'Ontario, portant sur une initiative financée par le gouvernement provincial, c'est-à-dire la constitution d'équipes communautaires de gestion de crise dans les localités des Premières Nations Nishnawbe Aski. Les équipes de gestion de crise, exemple authentique d'autodétermination, constituent une innovation majeure qui permet aux Autochtones de gérer et de fournir à leurs propres communautés les services dont elles ont besoin. Dans ce contexte, l'autodétermination comprend la création, le maintien et le contrôle de services à la communauté en réponse aux besoins identifiés par cette dernière. Créées au niveau local en réaction à une épidémie de suicides dans la région, ces équipes ont évolué en fonction de l'expérience immédiate ou en réponse aux priorités locales. Aujourd'hui, les équipes sont financées dans le cadre de la Stratégie de ressourcement pour le mieux-être des Autochtones, une initiative issue d'un partenariat entre les Autochtones et le gouvernement provincial et qui appuie les programmes élaborés et mis en place au niveau local. Les processus établis par la Stratégie ont été standardisés et rationalisés afin de pouvoir gérer efficacement un ensemble diversifié de programmes à travers la province, mais cela semble avoir eu pour effet de restreindre dans une certaine mesure l'autonomie locale, qui est un atout fondamental des programmes communautaires qu'elle appuie. Notre étude se penche sur ce paradoxe en examinant comment la réussite de l'autodétermination autochtone peut, à certains égards, en limiter la portée.

Summary

Over a comparatively short period, and at an escalating pace, self-determination has become the defining characteristic of Aboriginal-specific health policies and, to some extent, practices in Canada. This has occurred against a backdrop of improving, but still very poor, health status among our First Nations, Métis and Inuit citizens, whether they live in urban centres, in rural communities or on reserve lands. Few would question that self-determination is a necessary condition for the continuing improvement of Aboriginal people's health, but actualizing it is a complex process and may not play out as expected, at least in the near term.

Aboriginal people in Canada receive health care through a system of services provided by the federal and provincial or territorial governments, as well as by Aboriginal organizations — a complicated system based on a mix of jurisdictional concerns, legal interpretations, policies and established practices. To provide a context for considering the shift to self-determination that has occurred in the realm of Aboriginal health in this country, the authors of this study begin by answering two questions: "Who does what?" and "Who is responsible for what?"

They then offer an overview of the evolution in thinking about Aboriginal people's roles in controlling their own health care systems and describe the steps taken toward assuming those roles. The primary focus is on developments at the federal level, especially the Aboriginal Health Transfer Policy, because these initiatives set the stage for what has taken place provincially and territorially. However, provincial and territorial governments provide the majority of services to Aboriginal people. Policies and programs vary in their particulars from province to province and between territories; but the underlying principles are essentially the same, as are many of the challenges and outcomes. The authors therefore use Ontario — home to almost 20 percent of Canada's Aboriginal people — as a proxy to explore the effects of self-determination on the quality of life typically found in more remote parts of the country.

This paper uses an extended case study from northern Ontario and involving a provincially supported initiative — community crisis teams in Nishnawbe-Aski First Nations settlements — to illustrate the strengths, weaknesses and paradoxes that emerge from the implementation of locally controlled health programs. The crisis teams are a real example of self-determination; they represent a major change that allows Aboriginal people to manage services and deliver them to their own communities. As a concept, self-determination involves the creation, maintenance and control of services by a community in response to needs identified by the community. Evolving from a grassroots response to a region-wide suicide crisis, they were shaped by on-the-spot experience or dictated by local priorities. The teams are now funded through the Aboriginal Healing and Wellness Strategy (AHWS), a joint Aboriginal-Ontario initiative that supports community-designed and delivered programs. AHWS has standardized and streamlined its processes to effectively manage a diverse group of programs province-wide; but in doing so, it appears to have curtailed some of the local autonomy that is the fundamental strength of the community-based programs it supports. This paper examines this paradox by looking at how the success of Aboriginal self-determination can, in some respects, become its limitation.