Lost in Maps: Regionalization and Indigenous Health Services

COMMENTARY

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ABSTRACT

The settlement of the land now known as Canada meant the erasure – sometimes from ignorance, often purposeful – of Indigenous place-names, and understandings of territory and associated obligations. The Canadian map with its three territories and ten provinces, electoral boundaries and districts, reflects boundaries that continue to fragment Indigenous nations and traditional lands. Each fragment adds institutional requirements and organizational complexities that Indigenous nations must engage with when attempting to realize the benefits taken for granted under the Canadian social contract.

This paper discusses how the implementation of regionalized forms of health system governance at the provincial level continues to perpetuate state-centric territorial administration and control of Indigenous peoples and Indigenous health and well-being, imposing new boundaries on Indigenous territories, fragmenting and marginalizing Indigenous communities and perspectives and further splitting service delivery across a proliferation of jurisdictions. The argument is organized along three main themes. The first discusses the colonial imposition of territorial boundaries and the resulting impacts on Indigenous health and well-being. The second distinguishes concepts of colonial territoriality from Indigenous land-based reciprocity, examining the impact of the colonial territorial paradigm on treaty-making, land claims and health governance and delivery. A final section explores issues of Indigenous representation on health authorities (HA)/boards as a counter to imposed territorial paradigms. We conclude with key lessons.

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Colonization: Imposing Federal and Provincial Control over Health Services

Prior to colonization, Indigenous peoples living in what is now known as Canada, existed within their own jurisdictions and governed themselves according to their own legal, social and political systems. As a result, Indigenous nations were responsible for the health and well-being of their people and enjoyed a measure of well-being much higher than is currently observed in a majority of Indigenous communities across Canada (Boyer 2014). Colonization and the establishment of Canada entailed a unilateral imposition of federal and provincial jurisdictional boundaries on Indigenous communities, and the imposition of healthcare systems.

The British North America Act (renamed the Constitution Act) of 1867 created a jurisdictional divide that remains to this day. Under section 91(24), "Indians and lands reserved for Indians" were allocated as a federal responsibility under federal jurisdiction, whereas the responsibility for healthcare was allocated to the provinces, leaving Indigenous health in this jurisdictional gap. The current jurisdictional map counts fourteen healthcare systems. The thirteen provincial and territorial governments are responsible for the delivery of a range of health services, defined by the Canada Health Act 1984. The Act mandates publicly provided hospital and physician services, leaving room for regional variation of ensured services based on provincial priorities, such as Pharmacare or long-term care.

The fourteenth, and often forgotten healthcare system, is provided by the First Nations and Inuit Health Branch (FNIHB) of Health Canada, which funds and, to a lesser extent, delivers healthcare services to First Nations living on-reserve (all provinces and in the Yukon) and Inuit (in Newfoundland and Labrador only). The federal government has the prime responsibility for a complement of prevention and primary care health services provided to "Status Indians"[1] living on reserve and to Inuit living in their traditional territories in Québec and Labrador. This system does not, at the moment, provide services to Métis, who only recently have become acknowledged as eligible to federal programs as defined under the Indian Act (2015 Daniels v Canada). At the time of writing, Métis are still awaiting the final decision of the Supreme Court of Canada. However, it appears unlikely that FNIHB, which has been actively engaged in transferring its role as the provider of health services to First Nations for

three decades (Lavoie et al. 2009: 18), and in off-loading responsibilities to provincial jurisdictions (Lavoie and Forget 2006), might step forward to extend health services to Métis.

Federal and provincial policies move at different paces and follow different priorities, sometimes closing jurisdictional gaps, though often opening new ones. Given this combination of multi-jurisdictional boundaries and service variation, services provided to First Nations, Métis and Inuit peoples[2] are often the subject of jurisdictional disputes (Lavoie et al. 2015; The Jordan's Principle Working Group 2015).

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Territoriality, Treaties and the Governance of Health

The paradigm that underpins jurisdictional boundaries is based on the concept of territoriality or the exclusive control of bounded geographic space and the contents, including people, within those boundaries (Sack 1986). The colonial imposition of territorially defined authority imposes forms of spatial organization and conceptions of geographic space that predetermine the kinds of relationships between people, places, things and authorities that are possible within a given jurisdiction (Kornelsen 2015). The colonial state, then, is taxed with developing putatively just forms of the distribution of resources (including healthcare) across those living within these fixed boundaries. This concept of territoriality is at odds with many Indigenous epistemologies that understand jurisdictions and just distributions in relational terms – that is, that land is not something to be arbitrarily divided and controlled but something to build relationships with. This paradigm extends to the just distribution of "resources" or obligations between individuals and between communities that are defined and underwritten relationally, by developing respectful/reflexive relations of reciprocity (Asch 2014; Simpson and McDonald 2011) as expressed in traditional practices of treaty-making. The colonial project is continuously focused on displacing Indigenous concepts of land and stewardship, in favour of a static notion, aligned with the concept of private property and its mutually exclusive use of land set by static boundaries.

This territorial paradigm framed the establishment of the Canadian federation as well as the very practice of treaty-making in colonial contexts (historically and in the present) in ways that not only directly contradict Indigenous rights to self-determination but also continue to have significant deleterious effects on Indigenous health and well-being. Indigenous rights are entrenched in the Royal Proclamation of 1763 (King George 1763) – a document issued to clarify the rights of the French and Indigenous minorities following the conquest of New France by Britain. This document states that the Indigenous population is not conquered; they retain title over their ancestral territory and encroachment must be negotiated and settled by Treaty. As can be seen in Table 1, the signing of Treaties (1871–1921) and land claims agreements (1975 to present) were and are intended to "settle" issues of territoriality and federal obligations, based on this concept of exclusive use. The result is a patchwork of territorially defined jurisdictions of exclusive control, perpetuating disagreement between federal or provincial authorities on who is responsible for the "contents," as well as pitting Indigenous communities against each other as they vie for federal/provincial resources. The imposition of new territorial boundaries on Indigenous nations, which arbitrarily fragmented some nations across different jurisdictions, also resulted in a constellation of small discrete communities.

Table 1. Treaties and self-government activities in relation to Indigenous health

Agreement	Signed	YK	NWT	NU	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NFLD	Relationship to Health		
															Some control over health services	Input into policy/ regulations	Commitment for specific services
Treaty No. 1 (Canada 1871)	1871							✓									Implied commitments
Treaty No. 2 (Canada 1871)	1871						✓	✓									
Treaty No. 3 (Canada 1873)	1873							✓	✓								
Treaty No. 4 (Canada 1874)	1874						✓	✓									
Treaty No. 5 (Canada 1875)	1875						✓	✓	✓								
Treaty No. 6 (Canada 1876)	1876					✓	✓										Medicine Chest clause
Treaty No. 7 (Canada 1877)	1877					✓											Verbal commitments, none included in the text of the Treaty
Treaty No. 8 (Canada 1899)	1899		✓			✓	✓										
Treaty No. 9 (Canada 1929)	1905 –06								✓								
Treaty No. 10 (Canada 1906)	1906						✓										
Treaty No. 11 (Canada 1921)	1921	✓	✓														
James Bay and Northern Quebec Agreement (Canada 1974)	1975									✓					✓		
Northeastern Quebec Agreement (Canada 1984)	1978									✓						✓	
Inuvialuit Final Agreement (Canada & Committee for Original Peoples' Entitlement 1984)	1984	✓	✓													✓	
Sechelt Indian Band Self-Government Act (Canada & Sechelt Indian Band 1986)	1986				✓											✓	
Métis Settlements Act (Alberta & Metis Settlements General Council 1990)	1989					✓										✓	
Gwich'in Comprehensive Land Claim Agreement (Indian and Northern Affairs Canada 1992)	1992	✓	✓													✓	

Agreement	Signed	YK	NWT	NU	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NFLD	Relationship to Health		
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The Umbrella Final Agreement (Canada & Council for Yukon Indians 1993)	1993	✓														✓	
Sahtu Dene & Métis Comprehensive Land Claim Agreement (Canada & Sahtu Tribal Council 1994)	1993		✓													✓	
Nunavut Land Claim Agreement (Canada & Nunavut Tapariit Kanatami 1993)	1993			✓											✓	✓	
Manitoba Framework Agreement (Manitoba 1997)	1994							✓									
Indian Self-Government Enabling Act (British Columbia 1996b)	1996				✓												
Indian Advisory Act (British Columbia 1996a)	1996				✓												
The Nisga'a Final Agreement (Canada & Nisga'a Tribal Council 1999)	1999				✓										✓	✓	
The Métis Act (Saskatchewan 2001)	2001						✓										
Tlicho Agreement (Canada, Government of the Northwest Territories & The Tlicho 2003)	2003		✓													✓	
Carcross/Tagish First Nations Programs and Services Agreement Respecting the Indian and Inuit Affairs Program and the First Nations and Inuit Health Branch of the Government of Canada (Carcross/Tagish First Nation, Canada, & Yukon 2003)	2003	✓													✓	✓	

Treaties and land claims agreements make varying healthcare-related commitments to signatories. Of the historical Treaties (the numbered Treaties, signed between 1871 and 1921), Treaty 6, which includes over 50 First Nations in central Alberta and Saskatchewan, is the only one to make a healthcare-related commitment in writing. The Medicine Chest clause charges the federal government with the responsibility to protect First Nations people from pestilence and famine and to provide a "medicine chest" in the house of each Indian agent (Backwell 1981). While First Nations representatives view these provisions as the basis for a full federal obligation for health, the federal government has adopted the position that the provision of medical care is a matter of policy and not of right (Boyer 2004). This position is based on the 1966 Supreme Court of Saskatchewan, known as the Johnston appeal, which stated that "the [medicine chest] clause itself does not give to the Indians the unrestricted right to the use and benefit of the 'medicine chest' but such rights as are given are subject to the direction of the Indian agent." Therefore, according to this interpretation, the federal government determines the legitimacy of Indians' request for healthcare and to allocate it free of charge or at a cost (Canada 1966).

Since 1974, some lands claim agreements have included health-specific provisions. The James Bay and Northern Quebec Agreement (1975) and the Nisga'a Final Agreement (1999), give signatories some level of control over policy and health service delivery. The majority of these agreements, however, focus on input into policies and regulations over services to be provided by the province or territory. See details in Table 1.

The consequences of this jurisdictional uncertainty regarding health has been significant for First Nations, Inuit and Métis peoples in Canada. The federal government is responsible for providing health services for First Nations people living on reserve, primarily through contribution agreements to the bands to run these health services. Band-run programs are only provided funding for Status First Nations who live on their home reserve, leaving nearly half of Canada's First Nations people who live off reserve without funded access to on-reserve services. This limits the access that First Nations peoples living off reserve have to culturally appropriate services as they are forced to access mainstream systems for their healthcare needs. In addition, when there are gaps in coverage in on-reserve services, First Nations people living on the reserve do not necessarily get access to provincial services to address their unmet needs (The Jordan's Principle Working Group 2015). This jurisdictional boundary leads to significant inequities and gaps in continuity of care, given that on-reserve services do not have the same funding resources as the provincially run programs (i.e., availability of after-hours care). Small communities are also expected to compete for program funding for health and other services.

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Indigenous Participation as a Counter to Overlapping Maps and Jurisdictional Gaps

Trends in self-government have provided improved opportunities for First Nations and Inuit participation in service delivery. Agreements between federal and/or provincial health ministries/departments/HAs and First Nations and Inuit communities have multiplied. Self-government agreements have their own geographic boundaries.

Meanwhile, most provinces (with the exception of Prince Edward Island and more recently, Alberta and Nova Scotia) as well as the Northwest Territories have adopted decentralized models of healthcare delivery, which entails a transfer of authority from the Department of Health to regional authorities. Decentralization is intended to increase opportunities for citizen engagement in local priority setting, given that these regional authorities are tasked with priority setting and the allocation and management of health resources (Saltman et al. 2007). The relationship between Indigenous nations and HAs vary across the country. In effect, regionalization has added yet another level of complexity and variation in the complement of services accessible to all residents, including Indigenous communities.

Most decentralized provincial healthcare systems have not entrenched mechanisms to ensure Indigenous representation. Specific provisions are listed in Table 2. Ontario is the only province to have established a council composed of Indigenous peoples to advise on regional priority setting in healthcare, which is provided through the LHINs, although this is simply an advisory role. BC and Nova Scotia have had provisions that stipulate that the make-up of the Board of Directors must reflect the population that the RHAs are set up to serve; Indigenous peoples had not been specifically mentioned. This changed in BC as a result of the 2011 Tripartite Agreement on First Nations Health Governance, which includes explicit language to direct the HAs to work collaboratively with First Nations in the planning and delivery of health services (Government of Canada, Government of BC and the First Nations Health Society 2011). New tables for discussion and negotiation of First Nations priorities have been established in every regional health authority (RHA) in BC, although the scope has focused on Indigenous-specific services, rather than the full range of health services that Indigenous people use. This innovation is unprecedented and unique to BC.

Discussion and Conclusion

While commitments to self-determination create opportunities for some level of Indigenous control over selected health services, the entire framework remains mired in territorial assumptions that legitimize imposed colonial boundaries and the kinds of competitive, control-based relationships that follow. As such, federal, provincial, regional and Indigenous authorities over health services remain fragmented, and responsibilities debated. This is particularly the case for First Nations. The creation of HAs in most provinces did not resolve these issues. While Ontario (with Indigenous advisory committees for the LHINs) and BC (with regional tables on First Nations health) have established these advisory bodies to recommend and press for Indigenous priorities within the HAs, these are not recognized as decision-making bodies within those authorities, but rather to advise on Indigenous priorities. Therefore, legislation of provincial HAs has yet to guarantee Indigenous representation on their boards.

Although representation is important to advance the goals of Indigenous peoples in Canada, the appointment of a First Nations, Métis or Inuit individual on a board, tasked to represent all Indigenous peoples in the region, itself contradicts the principle of self-determination. And while Aotearoa (New Zealand) has engaged with this complexity and developed pathways (Lavoie et al. 2012), Canadian provinces have yet to begin these conversations.

Table 2. Indigenous representation in regionalized models

Province/ territory	Pop. 2015 (000)	% of pop. Indigenous	Number of RHA in 2015	Members are	Provisions entrenching Indigenous participation
YT	37	25	Not regionalized	N/A	N/A
NT	44	50	6+	Appointed	No specific provision to ensure Indigenous representation (Government of the Northwest Territories 1988, and amendments)
NU	37	85	Not regionalized	N/A	N/A
BC	4,683	5	5+	Appointed	Article 7.6.4 states that "the membership of public sector boards should reflect the cultural and geographical makeup of the population" (The Board Resourcing and Development Office 2007)
AB	4,196	6	1	N/A	N/A
SK	1,134	15	13	Appointed	No specific provision to ensure Indigenous representation (Saskatchewan Health 2008)
MB	1,293	15	5	Appointed	No specific provision to ensure Indigenous representation (Manitoba 2008)
ON	13,742	2	14	Appointed	According to the *Principles Governing the Appointments Process*, the "Persons selected to serve must reflect the true face of Ontario in terms of diversity and regional representation." The Local Health System Integration Act requires the creation of an Aboriginal and First Nations Health Council to advise the minister about health and health services related issues (Ontario Public Appointment Secretariat 2007)
QC	8,264	1	18	Appointed	No specific provision to ensure Indigenous representation (Governement du Québec 2005)
NB	754	2	2	Elected/ Appointed	No specific provision to ensure Indigenous representation (New Brunswick 2002)
NS	943	3	1	Appointed	According to the regulations, "the following are to be considered assets in the consideration of candidates for nomination: population characteristics such as age, gender, ethnicity, geography or membership in a disadvantaged group" (Nova Scotia 2000)
PE	146	1	1	N/A	N/A
NL	528	5	4+	Appointed	No specific provision to ensure Indigenous representation (Government of Newfoundland and Labrador 2005)

Pop. = population.

A possible pathway is now being travelled by the BC First Nations Health Authority (FNHA). Created as a result of a tripartite agreement set to address health and other inequities experienced by First Nations, BC is witnessing a new era in Indigenous health.

This new era has enabled: forging a relationship between the FNHA and the BC Ministry of Health; facilitating partnerships between First Nations and the HAs in all five BC regions; working toward greater policy and service integration throughout the province; and recognizing that Indigenous health is a joint responsibility of all the partners. The impact of this shift has not fully materialized, but it has brought key health and First Nations leaders to the table to collaboratively address the gaps in Indigenous health in ways not seen in other parts of Canada. It remains to be seen whether new governance formulations like this can adequately inject norms of relationship-building and reciprocity reflective of an Indigenous worldview to define relations between Indigenous nations themselves, and between Indigenous nations and federal and provincial authorities (Government of Newfoundland and Labrador, 2005).

Notes

1. The term "Indian" is a remnant from colonial confusion (related to Columbus' belief that he had "discovered" a route to India) that remains in legal documents. "Status Indians" are those individuals recognized as Indians as defined in the *Indian Act 1985*, c. This recognition confers eligibility to certain services and programs.
2. In Canada, the term "Aboriginal" is entrenched in the *Constitution Act*, 1982, and includes First Nations, Métis and Inuit. Aboriginal is used here when referring to historical references, otherwise the terms First Nation, Métis and/or Inuit are used. The term "Indigenous" is the preferred global term.

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