FIRST NATION-MANAGED HEALTHCARE ORGANIZATIONS

OPPORTUNITIES, CHALLENGES AND TRENDS

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Outline

1. Why we have more Indigenous-managed health services than Australia?
2. What models are in place
3. How it works
4. What works well
5. What we are still working on
What we have? A different history

North America, circa 1750

Source: wikimedia.org
What we have? The Royal Proclamation, 1763

- His majesty issues the Royal Proclamation, declaring the French a conquered people;
- States that Aboriginal people are not conquered;
- Guarantee Aboriginal sovereignty over their ancestral territory;
- Forbids encroachment by settlers;
- Establishes the Crown as sole legitimate authority to acquire Aboriginal land;
- Remains the backbone of every court case.
What we have? Confederation, 1867 and the Treaties

- Canada becomes an independent country, resource-rich with no economy;
- Indian Act 1876: in place to contain “Indians” on reserves and open land for farming;
- Signing treaties was key to the process: trading uncertain rights to traditional territory for clear title over a post stamp and some benefits;
- Sets up an administration on reserve: Chief & Council.
Establish Indian Affairs as a federal jurisdiction: *They will be too expensive to fight, and humanity won’t tolerate that we let them starve* (John A Macdonald, first prime minister of Canada).

Health care is a provincial jurisdiction.

The federal government begins to provide services on-reserve to respond to settlers’ concerns that epidemics on-reserve (chicken pox, TB, measles) threaten the settlers’ health.
What we have? Debates over a Treaty Right to Health

- Depends on who you ask

- Medicine Chest Clause (Treaty 6):
  
  "That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent... That in the event of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant to the Indians assistance of such character and to such extent as Her Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians for the calamity that shall have befallen them."

- The federal government still denies having a Constitutionally defined obligation to fund/provide health services on-reserve: a matter of policy that can (try to) change any time.
What we have: Models in place

- Contracted out system from the federal government since 1974/1989
- 1974, single small classical contract (Community Health Rep and Addiction Workers)
- Since 1989, 3 options:
  - A collection of classical contracts
  - Integrated: one relational contract for 3 to 5 years based on a community defined health services plan, with limited autonomy (60% of funding)
  - Transfer: one relational contract for 5 years, based on community defined health services plan, with full budgetary line flexibility (60% of funding)
And this is what this translate to:
On-reserve health services

- 10 provinces, 3 territories, 14 health care systems
What we have: A systems that delivered on outcomes

Lavoie JG, Forget E, Prakash T, Dahl M, Martens P, O'Neil JD. Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? Social Science and Medicine, forthcoming (June 2010).
What we have: More flexibility is better

Impact of signing a transfer agreement on rates of avoidable hospitalization

What we are still working on: Appropriate funding

- Vulnerable to cut backs
- A significant proportion of all new allocations is absorbed by the bureaucracy

What we still working on: Growing First Nation health expenditures

Per capital health expenditures (primary health and hospital care) in constant 2009 dollars

- By 2029, 11% of the Manitoba’s population (First Nations) will be consuming 32% of health budgets.
- This is not sustainable.

What we are still working on: Policy Renewal towards Comprehensive Primary Health Care

- National benchmarks
- Definition of essential primary health care services (Tilton & Thomas)
- New financial arrangements, streamlined reporting and health information systems
What we are still working on: Healthy Aboriginal Health Policy

- Community-based services are a small fragment of the health services accessed
- All services must be responsive
- Jurisdictional confusion must be sorted out
- Some provinces have developed Aboriginal health policies
- No province has a mechanism to ensure that Aboriginal peoples have a voice on Regional Health Boards
- Patchwork of legislation and policies, with huge gaps
- We need a national policy framework that respect the Constitutional autonomy of the provinces and the territories, and Section 35 of the Constitution (Aboriginal self-government)

Key messages

- Our context is different
- We have some issues sorted out: CC works,
- Some challenges are common to both countries
- We have been learning from you