Caught at the Crossroad: First Nations, Health Care, and the Legacy of the Indian Act[1]

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Abstract

This paper focuses on how the Indian Act 1985, is contributing to the disintegration of the parallel health care system designed to serve the needs of First Nations people living on-reserve. We use data from the province of Manitoba to illustrate trends that are happening across Canada. Specifically, we estimated First Nations health expenditures for the year 2003–04 for all agencies which share a responsibility for First Nations health services. We then projected these expenditures to 2029. Based on an analysis of First Nations health, we estimate that by 2029, First Nations Health Organizations may face an additional $23M (2004 constant dollars) in health care costs for which they receive no funding. In the last decades, federal policy frameworks have shifted their focus from assimilation to participatory processes and some measure of political autonomy. While attractive, our study shows that current policies entrench jurisdictional gaps, which will result in significant cost-shifting from the federal government to provincial and First

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Nations authorities. Current funding mechanisms are, however, impervious to this shift. The implication is a potential reduction in access to appropriately funded and responsive primary health care for First Nations people in Canada.

Key words: Canada, Indigenous peoples, policy, primary health care, equity, financing, Indians

Introduction

Relationships between First Nations[2] and the nation-state have moved through several eras. Early institutionalized contact policies (pre-1860) recognized First Nations as foreign to the Crown thereby supporting the right to conquer and rule them. Next, an era of post-Confederation protective paternalistic policies (1860–1920) saw the establishment of the reserve system and the adoption of the Indian Act 1876, which established First Nations as wards of the state. Assimilative paternalistic policies followed (1920–1960), with the growth of residential schools which had a devastating effect on First Nations language, cultures, communities, and families (Havemann, 1999). The cumulative effects of these successive waves of policies are deeply felt in First Nations communities today (Royal Commission on Aboriginal Peoples, 1996; Native Women's Association of Canada, 2007).

More recently, policies respecting cultural identity and providing some measures of political autonomy have emerged. As a result, state-First Nations relations are defined by legislative and policy frameworks that create parallel institutions addressing the unique needs of First Nations, and echoing their aspirations for self-determination. Canadians often express discomfort with the idea that services commonly delivered through government institutions could be divested to First Nations authorities. This is sometimes referred to as *citizen plus* provisions, demonstrating preferential support for services on the basis of ethnocultural identity, representing even greater entitlements to First Nations, who in the eyes of many Canadians, are undeserving of such opportunities (Newhouse, 2004). At the governmental level, such divestment is met with shifting levels of political commitment for appropriate financing (Lavoie et al., 2007). Nevertheless, and in the context of health services, the federal government continues to promote First Nations-controlled health services as the preferred mechanism for alleviating the health inequalities (Lavoie et al., 2005). The need to promote

2. The collective term First Nations is the preferred self-referent used by the indigenous peoples historically known as "Indians" (Indian and Northern Affairs Canada, 2002).

First Nations' participation in policy and program design, as well as service delivery, is constantly emphasized (Fiske and Browne, 2006).

As in any text, policy documents are textual constructions embedded in a historical, political, and social context. The language and content of policy documents is more likely to reflect the need to mediate the political landscape than to truly outline how policy statements and objectives are to be translated into practice. Apthorpe (1997) writes,

> Policy language ... is itself a form and source of policy power. Policy discourse tries more to persuade than describe; genre and style are integral to policy paradigms, not adornments to be dispensed with if they do not please. It is not through its language alone that the general nature (if there is any such thing) of policy or a policy analysis can or ought to be comprehended.

This paper focuses on the current Indian Act and the parallel health care system designed to serve the needs of registered First Nations people living on-reserve. It summarizes the findings of a larger study commissioned by the Intergovernmental Committee on Manitoba First Nations Health (Lavoie and Forget, 2006).[3] We begin with an overview of the Indian Act 1985 and a proposed amendment, and a discussion of issues related to access to health services. This is followed by a case study of First Nations health expenditures in the province of Manitoba, documenting the cost-shifting that occurs in response to changes to the Indian Act. More controversially, it also documents the disintegration of a system of health care financing and delivery designed to serve the needs of First Nations. As a result of this disintegration, barriers to accessing on-reserve primary health care will have a substantial impact on secondary and tertiary care, and provincial health care budgets. Manitoba was selected for this study because, along with Saskatchewan, Manitoba is home to the highest proportion of First Nations peoples in Canada, at nearly 10% of the provincial population. In this study, Manitoba illustrates trends that are happening across Canada.

Caught at the Crossroad: the Indian Act and Parallel Health Services

Defining Who is "Indian" in Canada

Who is and who is not an Indian is a politically charged question. In countries that share a common colonial history, namely Australia and New

2. A copy of the full report is available at http://www.manitobachiefs.com/issue/icfnh/ICFNH%20Financial%20analysis%20report%20%20Feb14%202007.pdf.

Zealand, terms of inclusion and exclusion in relation to indigenous people have alternatively been defined on the basis of genetics, "race," ethnicity or culture. Lately, relational terms have been validated in Australia: for example, an Aboriginal or Torres Strait Islander person is one recognized as such by members of their community, and in New Zealand, Maori are able to self-identify.

Many First Nations people in Canada also use relational terms to reflect cultural affiliation with a particular Nation, but the bureaucratic construct of Indian is closely guarded by the federal department of Indian and Northern Affairs Canada,[4] which maintains the current Indian Registry. The Indian Act historically and currently limits the legal category of "Indian," which, in turn, determines who has the right to live on-reserve, access Indian-specific federally funded programs and services, and qualify for certain individual-based health, social, and education benefits. The bureaucratic construction of "Indian" as defined by registration is a poor proxy for cultural affiliation (Fiske, 2006). Bureaucratic definitions have changed over time, reflecting values and assumptions embedded in the Canadian body-politic, rather than indigenous identities, practices, and self-definitions. For example, until 1985, a status First Nations woman who married a nonstatus man lost her Indian status and all entitlements therein. The same applied to a woman's children from such a marriage. As a result, many women and children lost the right to live on-reserve with their relatives. In contrast, a non-First Nations woman (of European or other origin) who married a First Nations man gained Indian status.

This "bleeding off" of First Nations women and children from their communities was in place for 116 years from 1869–1985. After organized protests from First Nations women leaders, this discriminatory provision was removed from the Indian Act with the adoption of the 1985 Bill C-31 (Lawrence, 2008, p. 65). This amendment to the Indian Act has, however, created further controversies. The dramatic increase in the population size of those entitled to access services offered on-reserve in First Nations communities was not accompanied with adjustments in community health and other services budgets, and concerns over sustainability have been raised (Lavoie et al., 2005; 2007). The amendment entrenched provisions that constrained the eligibility of status First Nations for registration under

4. INAC is the federal department responsible for maintaining the central repository of registered First Nations people. INAC is also responsible for funding on-reserve infrastructure, housing, social assistance, education, policing, and child protection services on-reserve.

the Indian Act after two generation of exogamous parenting.[5] Individuals of First Nations ancestry not eligible for registration under the Indian Act are generally called "nonstatus" or "non-registered Indians." For these individuals, funding for health and social programs does not come from the federal government. They are, instead, presumed to fall under provincial jurisdiction, and have the same rights to access programs and services such as health care, income assistance, and education as any other Canadian resident in their province or territory of residence. In theory, the jurisdictional carving is neat. In practice, however, the jurisdictional carving is far more complex. The Indian Act 1985 has resulted in increasing numbers of individuals of First Nations ancestry ineligible for registration (Clatworthy and Four Directions Project Consultants, 2001; 2005): these individuals and families, who may be born on-reserve and share the culture, language, and health and social needs of community members, are denied access to the same culturally appropriate services, including the right to live on-reserve, as a result of a bureaucratic provision.

In April 2009, the Court of Appeal for British Columbia ruled in the case of *McIvor v. Canada* (hereafter the McIvor decision) that the Indian Act 1985 discriminates between men and women with regard to Indian status. This ruling addresses what is known as the "double mother rule," an issue that emerged as a result of Bill C-31.[6] The Court ruling required the Federal Government to have a remedy in place by April 6, 2010. A request for extension was granted in early April, with a new deadline of July 5, 2010. The Federal Government has been working on a proposed amendment to the Indian Act, known as Bill C-3, which will result in an estimated 45,000 individuals becoming eligible for registration (Indian and Northern Affairs Canada, 2010). The impact of the proposed amendment on the above analysis is speculative as the Bill is still in draft form at the time of writ-

5. As the legislation stands, First Nations that have never lost their Indian status are registered as "Indians" under the Indian Act article 6(1). Those who lost status by marriage or other discriminatory means prior to 1985 are eligible for registration under the Indian Act article 6(2). Both 6(1) and 6(2) classification categories imply full status and benefits. Children of parents classified as 6(1) are classified as 6(1). Children of a 6(1) parent and 6(2) parent are classified 6(1). Children of a 6(1) parent and a nonstatus are considered 6(2). Finally, children of a 6(2) parent and nonstatus parent are considered nonstatus.

6. The "double mother rule" relates to children of Indian women who lost their status prior to 1985. As a result of Bill C-31, these women were allowed to regain their status. Their children were, however, classified as 6(2) under the Indian Act. This was not the case for children of nonstatus mothers and status fathers, who were classified as 6(1). Thus, children of women who recovered their status were deemed to have been discriminated against, on the basis of gender.

ing (House of Commons of Canada, 2010), and estimated impacts are still being discussed (Standing Committee on Aboriginal Affairs and Northern Development, 2010).

Jurisdictional Boundaries in Health Care

The Constitution Act, 1867 (formerly called the British North America Act, 1867, and still known informally as the BNA Act), encompasses the original creation of a federal dominion and defines much of the operation of the Government of Canada. Among other provisions, it defines health care as a provincial jurisdiction, and Indian affairs as a federal jurisdiction, thereby beginning a jurisdictional debate over Indian health which remains current. Following Confederation and the push to create a sustainable agrarian economy, the Crown engaged in Treaty negotiations with First Nations throughout the prairie provinces. The 11 numbered Treaties, as they are known, are land surrenders agreed to in exchange for reserve land, as well as other provisions such as rations in time of famine, medicines, and agricultural implements (Morris, 1880). For First Nations, the signature of the Treaties must be understood as an exercise in self-preservation, in light of the American Indian Wars, the demise of the buffalo, and the devastating impact of epidemics (Coates, 1999).

The settlers who arrived at the turn of the last century were concerned that the appalling health conditions on Indian reserves could lead to the spread of epidemics. The federal government's answer was to hire a General Medical Superintendent in 1904 and set up a mobile nurse visitor program in 1922. The first on-reserve nursing station was set up on the Peguis Reserve, then part of the Fisher River Agency, in Manitoba in 1930. Indian Health was incorporated into the National Department of Health and Welfare when formed in 1944, and federally controlled health facilities were built on most Indian reserves to provide primary health care delivered mostly by nurses (Waldram et al., 2006).

The Canadian national health care system, established in 1970, is a publicly financed, publicly administered, and partially privately delivered system, managed by the provinces under the umbrella of the Canada Health Act. The creation of a national health care system did not end the separation of jurisdiction in health care for First Nations. Off-reserve services remain the responsibility of the provinces. Public health, primary, secondary, and tertiary health care services can be accessed at no direct cost to the individual,[7]

7. Co-payments and access fees were made illegal in 1984.

via Medicare, the publicly funded health insurance scheme (Health Canada, 1999).

On-reserve services complement this system, but remain separately funded by the federal government. Services on First Nations reserves are largely limited to public health and health promotion. In isolated communities, services are broader in scope and include a mixture of primary health care, and primary medical care delivered by nurses with expanded scope of practice capacities, intermittent physician services, and local paraprofessionals (Tarlier et al., 2007). Other benefits and services such as eye glasses, medication, medical transportation, and dental care are provided under the Non-Insured Health Benefits (NIHB) program, which applies uniquely to registered Indians. Patients requiring secondary or tertiary care between visits or in an emergency situation are transported to the nearest provincial referral centre, often many miles away from reserve communities.

While somewhat coherent in theory, jurisdiction and rules of implementation create considerable complexities. Most Manitoba reserves include residents not eligible for registration under the Indian Act. These may be children of First Nations descent not eligible for registration as a result of Bill C-31, adults awaiting registration under Bill C-31, nonstatus or nonindigenous partners of First Nations residents, etc. As a result of housing shortages on-reserve,[8] some reserves neighbour nonreserve communities where First Nations, individuals of First Nations descent eligible and noneligible for registration, other indigenous and nonindigenous individuals live. Further, First Nations communities are small; Manitoba counts 63 communities with an average population of 1,118 residents on reserve (Indian and Northern Affairs Canada, 2004). Of these communities, 25 are considered isolated or remote isolated. Diseconomies of scale create challenges for recruitment of professionals.

For practical reasons, the federal government adopted a policy to cover the costs of providing primary health care benefits and services (excluding family physicians) to all reserve residents in communities classified as

8. The issue is complex, and a detailed analysis is beyond the scope of this paper. Suffice to say that title for reserve land is held in trust by the Minister of Indian and Northern Affairs Canada for a particular First Nations. While communal ownership has precluded the type of dispossession experienced by the Māori of New Zealand, for example (see Banner, 2000), a consequence has been to limit opportunities for the private financing of housing projects. As a result, the vast majority of housing on reserves across Canada is public housing, and has not kept pace with demands. We also acknowledge that some First Nations prefer to live off reserve, to facilitate private ownership, out of convenience, or for other reasons.

isolated and remote-isolated and to all residents living adjacent to those reserves, independent of status. This policy applies to 25 out of 63 communities in Manitoba, or 75 out of 476 communities nationally. For all other communities, however, funding for primary health care does not include reserve residents not eligible for registration under the Indian Act. In practice, the policy assumes that these individuals will travel to provincial health care facilities. This carving of responsibilities was intended to maximize the use of limited health resources by avoiding duplication in isolated and remote isolated communities, while reflecting federal-provincial jurisdictional boundaries in the majority of First Nations communities. Since these provisions were designed before the adoption of Bill C-31, they are poorly adapted to current circumstances. The current rules still anchor themselves to the geographical location of those served (on or off reserve), and fail to accommodate the diversity of living arrangements and mobility. There is no reciprocal arrangement to facilitate billing between jurisdictions. These jurisdictional cracks are compounded by Bill C-31 and will remain unresolved by the proposed Bill C-3.

Methods

An analysis of the jurisdictional funding arrangements for status First Nations people reveals that five separate agencies have responsibilities in First Nations health care. The First Nations and Inuit Health Branch (FNIHB) of Health Canada has the primary responsibility to fund all services delivered on reserve. In 2003–04, FNIHB delivered funding and/or services through 28 separate programs (Health Canada, 2003). The only program extended to off-reserve populations is the Non-Insured Health Benefits program, which provides all status Indians access to health care services not included under the Canada Health Act. Indian and Northern Affairs Canada (INAC) has limited responsibilities in the area of health, beyond that of infrastructure and long-term care. Manitoba Health (MH), through the Regional Health Authorities, is responsible for acute care costs and physician services for the entire population through its insured benefits branch. The Regional Health Authorities also deliver a number of community-based services for Manitobans living off reserve, and some provincial health programs are accessible to First Nations (such as home care). These programs operate off reserve only, with the exception of some costs paid for adult care in long-term care facilities on reserve. Manitoba Family Services and Housing (FSH) also provides services to some First Nations who live off reserve and participate in the Employment and

Income Assistance program. In families where one or more members does not have Indian status, noninsured health benefits may be paid on behalf of an individual otherwise entitled to receive benefits through FNIHB. Some health-related expenditures including therapeutic diets, transportation, and other services are not dependent on a participant's Indian status and are available to all recipients of income assistance. The Public Health Agency of Canada (PHAC) also offers a number of off-reserve health programs. These do not specifically target First Nations living off reserve, but rather serve to reach vulnerable population including First Nations.[9]

Estimating Expenditures

To estimate First Nations health expenditures, we had to identify each agency's role and responsibilities for financing health services, based on government funders' annual reports supplemented with discussions with program staff from agencies.

Population Figures

The population figures used for the Manitoba case study came from two studies completed by Clatworthy (2001; 2005). These projections were based on the department of Indians and Northern Affairs' Status Verification system, and were developed to assess the long-term impact of Bill C-31. They take into consideration a number of key factors, including: (a) trends in population size by location (on and off reserve), including migration; (b) annual rates of population growth by locations (on and off reserve); (c) annual additions to the population through Bill C-31 registrations; (d) trends in the composition of the population by section 6 registry category and location (on and off reserve); and (e) the rate of exogamous parenting, or parenting between someone who is (or is entitled to be) legally registered under the Indian Act and someone who is not entitled to be registered.

Per capita costs were calculated over the whole relevant population, rather than just the people who used a particular program. This allowed us to add together expenditures on different programs to estimate total expenditure per person.

9. Other organizations also extend health and health related services to Manitoba First Nations: Manitoba Public Insurance covers health expenditures related to motor vehicle accidents; Private Insurance Carriers provide additional health coverage; Corrections Services of Canada provides health services to the inmate population in two institutions; Workers Compensation Board; Medical Transportation expenditures expended by the RCMP under the Mental Health Act; and expenditures from different programs and private sources. These expenditures were considered out of scope for this exercise.

Results

Figure 1 summarizes trends in First Nations population growth, both on and off reserve. According to the Clatworthy projections, the on-reserve population will continue to grow much faster than the off-reserve population. Both will experience a decreasing growth rate, associated with the loss of entitlement for Indian registration under the Indian Act. By 2029, a total of 29,186 individuals of First Nations ancestry (9,645 on reserve, and 19,541 off reserve) will not be entitled to Indian status. This is nearly 5 times the numbers of individuals not entitled to registration in 2004. As Lawrence (2008, p. 66) argues, while these demographic trends are disturbing, the cultural damage caused by the loss of status of so many First Nations people, largely women and children, who are now no longer recognized — and in many cases, no longer identify — as "Indian," is incalculable.

Figure 1. Manitoba First Nations Population Projections, 2004–2029

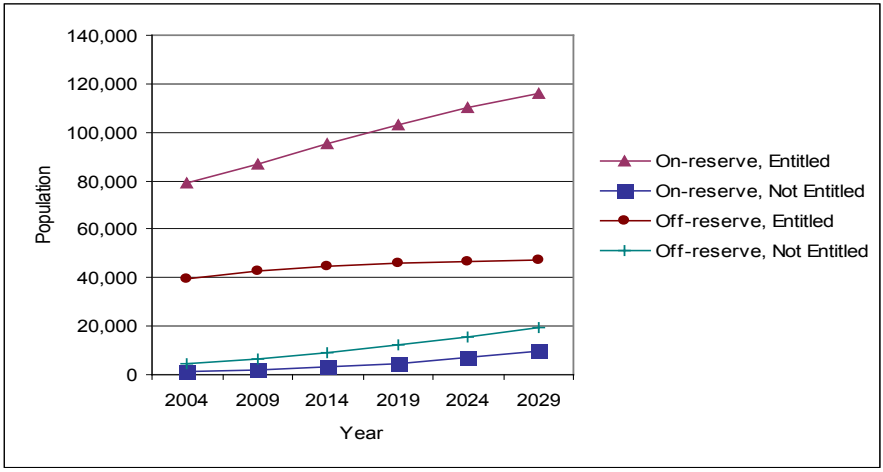

Table 1 projects health expenditures in constant dollars for the on- and off-reserve populations. The figures assume that all current policies regarding jurisdictions over health care will continue to apply and that per capita expenditure by each agency will remain constant. As a result of Bill C-31, health care costs not covered by either federal or provincial government are estimated to grow eight-fold on reserve and three-fold off reserve. This is because the provincial government picks up those no longer eligible for status if living off reserve. Neither government is currently picking up these costs on reserve.

Table 1. Total Projected Health Care Costs by Payers, based on Clatworthy's Projected Bill C-31 Impact, in Constant 2004 Dollars ($1000)

	Population living on reserve				*Population living off reserve*			
	Province	*Federal government*	*Costs no longer covered by either government*	*Total*	*Province*	*Federal government*	*Costs no longer covered by either government*	*Total*
2004	$193,070	$283,089	$2,559	$478,718	$155,697	$49,155	$4,121	$208,973
2009	$214,661	$313,278	$4,321	$532,260	$171,410	$52,634	$5,646	$229,690
2014	$237,320	$343,749	$7,371	$588,440	$187,402	$55,379	$7,754	$250,535
2019	$260,154	$373,327	$11,575	$645,056	$203,360	$57,423	$10,344	$271,127
2024	$282,610	$401,346	$16,782	$700,738	$219,050	$58,774	$13,352	$291,176
2029	$304,005	$426,791	$22,990	$753,786	$234,196	$59,362	$16,756	$310,314
% growth	57.5	50.8	798.4	57.5	50.4	20.8	306.6	48.5

Discussion

Canada's first and only Indian Health Policy was adopted in 1979 (Crombie, 1979). This policy has a single, broad-based objective:

> ... the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves. (Health Canada, 2000)

The policy reflects international debates (World Health Organization and UNICEF, 1978) and previous Canadian studies (Booz-Allen and Hamilton Canada Ltd., 1969; Hawthorn, 1966) on the importance of engaging First Nations in primary health care program planning and delivery:

> The Federal Government realizes that only Indian communities themselves can change [the] root causes [of health inequalities] and that to do so will require the wholehearted support of the larger Canadian community. (Health Canada, 2000)

Current constraints on registration under the Indian Act 1985 and the proposed Bill C-3 cut through the heart of the Indian Health Policy, and undermine attempts to address the health inequalities experienced by First Nations. As the Clatworthy projections show, registration rules imbedded in the Indian Act 1985 result in a rapid growth in the number of nonregistered individuals living on reserve, who require access to primary health

care despite their ascribed status. The proposed Bill C-3 will allow a small fraction of these individuals to be eligible for registration. Current policies suggest that those residing on northern reserves will continue to access services funded by FNIHB. Those residing on southern reserves may need to seek care outside the reserve and in provincial facilities. While appearing reasonable, challenges result from a spectrum of issues including poverty, lack of access to transportation, geography, and winter weather conditions, which physically contribute to limited access. Even when individuals can find their way to off-reserve services, however, research shows that tacit and overt discriminatory practices and policies continue to marginalize many First Nations individuals in the mainstream health care system (Browne, 2005; 2007; Tang and Browne, 2008; Varcoe and Dick, 2008). In part, negative health care experiences stem from encounters with a health care system that tends to reflect dominant discourses about First Nations people as relatively irresponsible, dependent, and in some cases, undeserving of health care, reflecting persistent stereotypes and misinformed assumptions.

Most First Nations communities now manage their on-reserve health services.[10] They find themselves morally obligated to serve all residents living on reserve (Lavoie et al., 2005), partly because many of the nonstatus individuals living on reserve are dependent children or partners of community members with status. Bill C-3 may make some of these individuals eligible for registration, but the federal government has so far failed to align funding with population growth. Based on our analysis of Manitoba data, we estimate that, by 2029, First Nations health organizations may face an additional $23M (2004 constant dollars) in the costs of providing health care. The implication is a reduction in access to quality primary health care, and, in some cases, suboptimal delivery of primary health care services stretched beyond their limits.

It seems unlikely that FNIHB will expand the scope of its coverage to include these individuals, for a number of reasons. Since 1994, FNIHB's policy has been to "get out" of the business of providing direct health service delivery (Health Canada [MSB], 1995). This is being implemented through two processes. First, across Canada, FNIHB has contracted out front line, and a selection of regional, services to First Nations organizations (Health Canada [FNIHB], 2001). This appears to have been done with cost containment in

10. The Health Transfer Policy was implemented in 1989, allowing First Nations to assume some level of control over community-based health services previously delivered by the federal government (Lavoie et al., 2005).

mind (Jacklin and Warry, 2004). First Nations who manage their health services have inherited budgets locked at the level of historical expenditures in place when they signed their first agreements, and with limited provision for population growth or needs (Lavoie et al., 2007). This reflects the limited growth in the FNIHB budget despite increasing demands. Although new funding has been introduced to address nationally defined priorities, these initiatives are generally funded as proposal-driven, time-limited projects, rather than essential services. Given these significant concerns, the sustainability of First Nations organizations and of FNIHB have been constant themes of the most recent Evaluation of the Health Transfer Policy (Lavoie et al., 2005). Policy discourses of First Nations "control" over locally delivered health services have additional consequences. Onus is placed on First Nations to redress and promote the health of communities, despite the lack of corresponding increases in health services funding. Failure to show improvements in health status, without First Nations control, fuels the lack of confidence in First Nations governance, and raises concerns respecting the costs of First Nations-administered programs, as two pervasive themes in Canadian public discourse (Fiske and Browne, 2006).

Second, some responsibilities historically funded by FNIHB are being unilaterally devolved to the provinces. This is the case for the five remaining on-reserve First Nations hospitals (two of which are located in Manitoba). In 2003, the federal Treasury Board informed FNIHB that its financial authorities no longer included the funding of hospitals. As a result, provincial and First Nations authorities have been left to assess the impact and rally to fill the gap left by FNIHB's retreat (Lavoie, 2006); the provinces[11] have generally resisted expanding their services on-reserve (Lavoie and Forget, 2006). It is unclear how this policy gap will be resolved. Emerging evidence shows a disproportionate utilization of secondary and tertiary care services for ambulatory care sensitive conditions by First Nations, suggesting barriers to accessing primary health care services (British Columbia Provincial Health Officer, 2009; Martens et al., 2002; 2005; Shah et al., 2003). Bill C-3 may well compound rather than resolve this situation.

Bill C-31 has also resulted in an even more rapid growth of individuals not eligible for registration under the Indian Act living off reserve. The proposed Bill C-3 will have a small impact on this trend. Here, the responsibility for all health care services will simply be shifted to provincial authorities. A remaining portion of health care costs not insured under the Canada Health

11. This is especially true in the have-not provinces of New Brunswick, Manitoba, and Saskatchewan.

Act, or under the NIHB program, including glasses, dental care, medical transportation, and medications, estimated at $16.8M by 2029 (constant 2004 dollars), will be shifted to individuals. This is a cause for concern. Disparities in socioeconomic status related to limited employment opportunities are well documented in the Manitoba off-reserve First Nations population (United Ways Winnipeg, 2004), and in off-reserve populations in other provinces, leading one to wonder how individuals may be able to shoulder these additional health care costs.

In many ways, and despite policy statements to the contrary, current constraints on eligibility for registration fit very well with the long standing national agenda of slowly shifting the responsibility for First Nations health care onto the shoulders of the provinces. Perhaps more importantly, these regulations cut through the very fabric of First Nations communities, and reinforce a disintegration of these communities in a manner that echoes policies many assumed had been relegated to the past (Havemann, 1999). The result may be a growth in social inequalities and unmet health care needs.

Key messages

- In Canada, official discourses promote participatory processes and some measure of political autonomy for First Nations, in the administration of government services, including health.
- In practice, these policies undermine attempts to address the health inequalities experienced by First Nations, create barriers to accessing primary health care on reserve, result in increased secondary and tertiary care and increased financial burden on provincial health care budgets.
- As implemented, current policies promote the disintegration of First Nations communities, and will result in increased social inequalities and unmet health care needs.

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