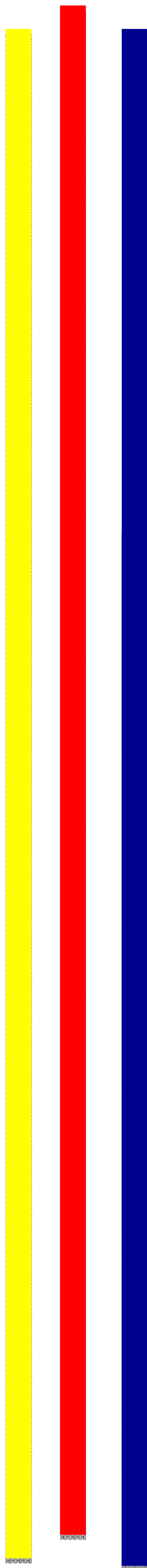

Introduction

This chapter uses the case of TB prevention and control as a prism through which to understand the complexity of intergovernmental relations when two policy fields -- Aboriginal policy and public health policy -- collide.[1] The challenges associated with federalism as they pertain to Aboriginal people generally have received significant academic and legal attention (see, among others, Abele and Prince 2003; Hanselmann and Gibbins 2005; Ladner 2003). The links between Aboriginal policy and public health have received comparatively less attention in the literature.

This chapter begins with an historical overview of the TB problem in Canada, paying particular attention to its devastating toll among Aboriginal populations. The second section discusses the broader field of intergovernmental relations and public health, before moving on to how TB fits into the public health field, and finally the distinctive challenges associated with TB prevention in an Aboriginal context. The next section examines the two provinces selected for this case study (Manitoba and Saskatchewan), describing the roles and responsibilities of the various levels of government in matters pertaining to TB. In order to provide a more complete picture, it is useful to discuss the jurisdictional issues related to Aboriginal people more generally, and how they relate to or diverge from the TB case. Is there something distinctive about the TB problem that provides an important lens through which we can examine the challenges associated with intergovernmental coordination in Aboriginal matters? Or are the obstacles to effective care, treatment, and prevention of TB owing exclusively to the public health dimensions of this policy problem? The answer, it appears, is a combination of both. I then evaluate the model of federalism that characterizes this governance relationship, and assess its strengths and weaknesses, drawing on interviews with key informants in both provinces.

Finally, I conclude with a discussion of some of the challenges that require attention if TB prevention, surveillance and treatment among Aboriginal populations are to be properly addressed as a pressing public health issue. Indeed, with regard to the former, some informants, albeit non-Aboriginal, were critical of Aboriginal leaders for failing to make TB prevention and controlc-0e0 Tc hpther to 9l

Table 1: Overview of Federal Services

Programs targeting all Aboriginal people	**Non-insured Health Benefits Program for all eligible First Nations and Inuit**	*** Programs available on all First Nations reserves and Inuit communities in Labrador**	**Programs available only in isolated and remote communities**
- Limited prevention and promotion programming (eg:			

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In some cases involving public health problems, notably communicable diseases, the

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past to repressive public health measures in an attempt to prevent the disease from spreading to the general population. Interestingly, governments at the federal, provincial and territorial levels continue to have the authority to detain individuals against their will for diagnosis and/ or treatment if they are seen to be non compliant. Even though this authority is rarely used – public health officials prefer to encourage voluntary compliance – "tuberculosis is the one communicable disease for which it continues to be invoked" (Long 2000, 170).

The challenges associated with preventing and treating tuberculosis are exacerbated in

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"modernize" the Indian Act, but attempts have failed largely because of the government's inability to secure support from First Nations' leaders. The latest effort, *The First Nations Governance Act*, was scrapped in early 2004 by the Liberal government of Paul Martin after it became clear that it lacked clear support (see Ladner and Orsini 2005). But as recently as Feb. 2009, it has been reported that the minority Conservative Government of Stephen Harper plans to introduce new funding policies for Aboriginal reserves as a way to address issues of transparency and accountability among Band councils. Phil Fontaine, National Chief of the Assembly of First Nations, warned that the federal government should think twice before trying to revive aspects of the First Nations Governance Act, which was roundly condemned by First Nations' leaders (Curry 2009).

Intergovernmental Relations and Public Health in an Aboriginal Context

In order to understand how TB control is managed in Aboriginal populations specifically, one must examine first how Aboriginal populations interact with the state in the area of health. The federal government, through the First Nations and Inuit Health Branch (FNIHB) of Health Canada, is responsible for the delivery of a number of health-related programs and services for First Nations and Inuit populations living on reserve, including the TB control program, fetal alcohol spectrum disorder program and chronic disease prevention programs. For the most part, these programs are delivered only to on-reserve populations. Acute care services, however, are delivered by the province to Aboriginal people, on and off reserve, just as the province offers these services to other residents of the province. Some exceptions are made for those in remote or isolated communities where there is limited access to care, for which FNIHB will assume the cost. In addition, FNIHB, through its Non- Insured Health Benefits program, provides supplementary services such as prescription drug coverage and dental care, to all status persons whether they live on or off reserve.

In 1979, the federal government introduced its Indian Health Policy, which recognized that achieving an increased level of health in Indian communities must be built on three pillars: community development in First Nations communities; the traditional relationship of Indians to the federal government and the Canadian health system. The Canadian health system was defined as composing "specialized and interrelated elements, which may be the responsibility of federal, provincial or municipal governments, Indian Bands,

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For fear of intruding on the authority of Aboriginal peoples to administer health programs on reserve, governments can claim that they are simply respecting the communities' interest to control their own affairs.

The federal government followed up a decade later in 1989 with the creation of the Health Transfer Policy, which was the culmination of years of discussion between Aboriginal representatives and the federal government with respect to resolving the problems associated with the Indian Health Policy. In particular, it sought to promote the transfer of control for on-reserve primary health services to First Nations, and to ensure that appropriate funding was in place to allow community-based assessment, hiring capacity to draft operation plans and negotiations. Yet, as one observer has noted, it made no provisions "to promote increased First Nation participation in all levels of the Canadian health care system" (Lavoie 2004, 9). An evaluation of the health transfer sounded some positive notes with respect to the realization of community ownership of health issues, but also identified "the lack of clarity in roles and responsibilities between First Nation and Inuit organizations, the province, and FNIHB" as a theme that recurred throughout interviews with respondents (Lavoie et al. 2005a, 12). These "unresolved ictionlh issue" weare snglvedhout asoundv

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Care in Canada 2002, 212). Aboriginal legal scholars regard this position as "disingenuous" and without regard for existing treaty rights. As Boyer argues (2004, 36),

> The federal government, under the auspices of Health Canada, cannot reasonably maintain that health services provided to First Nations and Inuit Peoples are "voluntary" and not required by law but simply a matter of policy. Such a characterization is a discriminatory reading of Canada's commitments to provide the highest attainable standard of physical and mental health to *all* residents of Canada and to facilitate reasonable access to health services without financial or other barriers based on need. Ironically, the federal government's policy recognizes and affirms the government's unique constitutional obligations to Aboriginal Peoples but fails to implement these obligations to certain existing Aboriginal and treaty rights – including access to health and health care. Instead, Canada's health policies and guidelines affecting Aboriginal Peoples' health should be examined to ensure that they no longer reflect the outdated wardship model of Crown/Aboriginal relations but instead reflect the fiduciary relationship that the Supreme Court of Canada has stated properly characterizes Crown/Aboriginal relations.

Aboriginal scholars interested in health often invoke the notion of the "medicine chest", contained in Treaty No. 6, which was signed in 1876 between the federal government and the Cree of central Alberta and Saskatchewan, as evidence of a governmental duty to provide free health care to Aboriginals. Treaty No. 6 has not fared well in the courts, however. As Jackman describes (2000, 107), the Saskatchewan Court of Appeal rejected this argument, suggesting that the Treaty "did not impose an obligation on the federal government to provide medical and hospital services to all Indians, nor did any federal legislation".

In addition to debates about treaty rights to health, the case of urban Aboriginal people, despite some marked progress, is far from resolved. As Hanselmann and Gibbins explain (2005, 79),

> Whereas the constitution clearly gives the federal parliament exclusive legislative authority for 'Indians, and Lands reserved for Indians', authority and responsibility for other Aboriginals is not so clearly delineated. The confusion is amplified in the case of Aboriginal residents of the cities, since they are at the same time urban and Aboriginal … the constitution does not assign responsibility for urban residents to either the federal or the provincial governments; indeed, the federal government's traditional position has been that … it has primary but not exclusive responsibility for registered or status Indians living on reserves, while the provinces bear primary but not exclusive responsibility for all other Aboriginal people. The provinces … have responded that all Aboriginal people are the primary responsibility of the federal government and that provincial responsibilities are limited to serving Aboriginal people as part of the larger provincial population.

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Despite decades of concern and a need for a clarification of federal and provincial roles in this area, and a range of federal statements touting the benefits of collaboration and coordination, Graham and Peters conclude (2002, 18) "there is no sign that basic issues of jurisdiction and responsibility are being addressed. In the context of high rates of movement between reserve/rural and urban areas, jurisdiction based on residency on and off Aboriginal territories would not seem to offer much in the way of policy and program integration and coordination". The final report of the Royal Commission of Aboriginal Peoples outlined three main problems faced by Urban aboriginal peoples: they "do not receive the same level of services as First Nations on-reserve or Inuit in their

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The provincial government, for its part, is responsible for providing basic health care services (such as hospital/physician visits, diagnostic tests) for all Aboriginal people,

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> Despite the advances of the last 50 years, tuberculosis control remains a challenging area of public health. Successful programs require an effective partnership of clinical and community-based agencies and a myriad of disciplines. Supporting the person with active tuberculosis through a long course of treatment requires public health expertise in the provision of education and innovative supporting mechanisms to ensure that the patient's basic needs are met, and to put in place the appropriate environment that will allow them to complete treatment. The results of failing to provide such a holistic approach have been amply demonstrated with the resurgence of tuberculosis in many urban centres in North America, and continue to be seen in selected geographic areas in Canada. In order to eliminate tuberculosis in the coming century, continued emphasis will be required on such factors as housing, income, and social supports as contributors to the prevention of transmission and successful completion of treatment.

Efforts to control, much less eradicate, TB have been hampered, however, by a plethora of jurisdictional ambiguities related to the coordination and delivery of public health interventions. As Wilson argues (2004, 409), although long ignored by the public health community, "intergovernmental cooperation" is emerging as "one of the most significant challenges facing public health today." And if relations among the federal government, and its provincial and municipal counterparts vis-à-vis public health weren't complicated enough, the addition of an Aboriginal component adds another layer of complexity, since tuberculosis control among Aboriginal populations not only requires the federal government to collaborate effectively with provinces and local or regional authorities, but demands that all three orders of government work constructively with Aboriginal governments on reserve as well as with, perhaps, Aboriginal organizations representing off-reserve Aboriginals.[3] Indeed, the Tuberculosis Elimination Strategy makes it abundantly clear (1992, 2) that "program planning, implementation and evaluation are based on community ownership and participation at all stages, and are strengthened and maintained by community and agency partnerships." Such collaboration with the local communities in question is especially crucial when one considers the importance attached to, for instance, Directly Observed Therapy (DOT) - "treatment which requires the patient to be seen by a second person during the course of his treatment to ensure that prescribed medication are taken as instructed in the presence of the second person" (1992, 14).

It is indeed a truism today to claim that public health activities in a federal system are complicated by a series of governance problems, many of which only bubbled to the surface following the arrival of SARS on Canadian soil in 2003. As Naylor noted in his report, *Learning from SARS*, there are federal legislative provisions to regulate food, drugs and pesticides, but no equivalent at the federal level for public health (National Advisory Committee on SARS and Public Health 2003, 48). Even the Canada Health Act, which is hailed as the fundamental expression of Canadian values with respect to health, does not refer to public health per se. And when it comes to disease surveillance, Naylor adds, "Health Canada does not have a clear legal mandate to require provinces/territories to share health surveillance data with each other and the federal ieamAdvisory Comm itteeh Canada does1 it co

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when poor communication or a clash of personalities can result in vital information not being exchanged. Although public health has emerged as a shared federal/provincial responsibility, there remains "ambiguity over ultimate constitutional responsibility in several specific public health domains" (Wilson 2004, 410). Even in those areas on which there appears to be some consensus, such as the ability to declare a public health emergency or the ability to quarantine persons with communicable diseases, the latter enumerated in Section 91 of the constitution, the federal government's ability to respond to a public health emergency without provincial consent "is dependent on how liberally the courts interpret federal powers that can be derived from the peace, order and good government clause"(Wilson 2004, 410).

Notwithstanding important questions regarding their etiology and patterns of incidence and prevalence, communicable diseases such as TB are of particular interest to health policy scholars because they can create important externalities and spillovers:

> A disease developing in one province affects not only that one province; it has the potential to affect other provinces across the country, either directly through spread of the disease or indirectly through stigmatization of the affected region. Thus, in many respects, the management of a disease outbreak is of national concern. If a province has the resources to adequately manage the outbreak, there would be no requirement for assistance from the federal government. However, at a minimum, a province should communicate information on the outbreak openly to other governments. Such information would allow adjacent provinces to prepare for the potential spread of the disease. Nevertheless, there are real disincentives for any provincial government to provide detailed reporting of the status of an outbreak, particularly at an early stage when there is uncertainty about the outbreak's magnitude.... Thus, it is conceivable that a province would be reluctant to report an outbreak out of fear of negative economic consequences or simply out of a belief that the matter was within their sole jurisdiction (Wilson and Lazar 2005, 11-12).

Although Wilson and Lazar are referring to diseases migrating from one province to another, this takes on a particular urgency in Aboriginal communities, as it widely known that Aboriginal people living on reserve often migrate, albeit temporarily, to the nearest city for extended periods of time, especially if that city is located close to a reserve. In addition, Aboriginal people living primarily in urban settings often migrate from one city to another in the same province, or from one province to another.

The nature and effectiveness of intergovernmental relations in public health: Saskatchewan and Manitoba

In order to illustrate some of the complexity inherent in TB control and prevention among Aboriginal populations, I chose to examine the nature of these interhu3ptn

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functions it previously had", this reorganization was hailed in the Health Canada report as a success (Health Canada 1999, 25).

Saskatchewan also has seen the rapid expansion of reserves in urban areas on land purchased by First Nations, "which has resulted in much confusion about who should be providing public health services on these urban reserves: FNIHB? First Nations? Or the local regional health authority?" (Assembly of First Nations 2006, 26).

Manitoba

The province is home to about 150,000 First Nations, of whom about half (72,000) live in 62 communities throughout the province. Thirty-two of these communities have negotiated Health Transfer Agreements with the federal government. In a handful of cases, the province of Manitoba is delivering public health services to them under what was known as "the 64 Agreement." As explained by the Assembly of First Nations report on public health, "this Agreement was signed in 1964 between the federal and provincial

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Description of Intergovernmental relations

How then might we characterize the intergovernmental relationships at play in the provinces? On the one hand, it seems fairly straightforward with the federal government assuming some degree of responsibility for

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response at the Aboriginal level and indirectly influence their own policy making processes, not to mention the resources internal to the Aboriginal community. It can also have a spillover effect if an on-reserve problem migrates off reserve and lands in the lap of the provincial government. It is also possible that the federal government could simply choose to abandon its Tuberculosis Elimination Strategy altogether, without being held to account for allowing a policy to simply lapse or fade into obscurity.

The relationship between Aboriginal and provincial governments could also be described as interdependent, although Aboriginal governments can often find themselves stuck in the middle of bickering between the provinces and the federal government. To their credit, the provinces generally have less baggage than the federal government when it comes to dealing with Aboriginal communities. In the case of Saskatchewan, there appears to have been greater cooperation between both levels of government than in Manitoba, where, up until recently, the main intergovernmental relationship in the field of TB control was between the office for TB control and the federal government. In Manitoba, it is important to stress that up until recently, TB control was devolved from the provincial government to a non-profit organization, the Lung Association. The decision to "harmonize" TB control into the provincial ministry of health occurred with little explanation when it was announced, however.

The relationship between the federal and provincial governments, with respect to First Nations and TB control, could be described as interdependent and non-f05 -1cwv 0 TDThe Naescribed a8ow

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Descriptive Analysis Framework:

Characterization of Intergovernmental Relationship

	Interdependence	**Hierarchical**	**Form of Relationship**
Federal-Provincial	Yes	No	Federal-Provincial Collaborative (with some disentanglement)
Federal-Aboriginal	Yes	No	Federal-Local Collaborative (with some coercion)
Provincial-Aboriginal	Yes	No	Provincial-Local Collaborative (with little coercion or disentanglement)
Provincial-Provincial	No	No	Interprovincial Disentangled
Aboriginal-Aboriginal	Yes	No	Interregional Collaborative

Evaluation of Intergovernmental relations

I now turn briefly to an evaluative analysis of the TB case using the outcome measures identified by Wilson and Lazar in their framework document. They are: policy effectiveness (impact on health and efficiency), impact on democracy, and federalism.

Policy effectiveness

In terms of policy effectiveness, the policy (Tuberculosis Elimination Strategy) has failed to reach its stated objectives of reducing the

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> Manitobans should expect are not being met. And I think they don't see TB as a priority.

As regards the coordination of public health activities across orders of government, there have not been any serious tests of the system's ability to respond to an outbreak. What is clear is how significant individual medical officers of health or other public health officials are in advancing policy discussion in the TB field. Indeed, TB is fortunate to have a few key so-called "policy champions" at the federal level and scattered throughout the provinces, who are known by everyone in the policy community. The danger, of course, is what happens to the intergovernmental relationship when its cast of characters is replaced. In some cases, this might present opportunities to forge new and productive relationships; in others, there may be a steep learning curve for those about to get their intergovernmental "feet wet".

Finally, complaint about the lack of a national TB control policy, much less a discussion, was voiced, primarily from the non-profit and medical community. Inside and outside the Aboriginal community, there is also a lack of coordinated public health policy discussion, whether at the local, provincial or federal level. The recognition that some Aboriginal communities lack the capacity to deal with the problem of TB control, coupled with their own acknowledgement of the difficult intergovernmental environment, led some to note the problems of economies of scale in Aboriginal communities.

Therefore the existing intergovernmental relations would be viewed as contributing to the lack of policy effectiveness of TB control in First Nations populations by creating confusion over roles and responsibilities, in particular funding, and perhaps most importantly creating a perception of lack of responsibility amongst specific governments.

It is clear that there are serious gaps that need to be addressed. While there is indeed collaboration with regard to data surveillance, although there have been differences of opinion with regard to the ownership of this data in the case of Aboriginal communities, it is unclear whether this can be attributed directly to the intergovernmental mechanisms in place. Rather, there is some sense that officials have succeeded in obtaining and sharing data in spite of the jurisdictional bickering that has surfaced. It might be perhaps more accurate to reflect on why so little attention was devoted at the time of the creation of the Tuberculosis Elimination Strategy to getting the "intergovernmental house in order" before embarking on such an ambitious plan to eliminate TB.

Federalism

From the viewpoint of the federal government, the legislative authority is clear – in fact, it's written down in black and white through the Constitution and various provincial health acts and health and social framework agreements implemented over the years. Others, however, disagree. While they acknowledge the various legally binding agreements, they point out the vagaries that exist when multiple levels of government are included and added to TB control issues. One Manitoba public health official (Interview, August 2005)' was critical of the federal government's so-called 'line in the sand' with respect to off-reserve Aboriginals:

> It's absolutely clear from FNIHB's (First Nations and Inuit Health Branch) point of view. They would not look after or pay for any status Indian off reserve. Nonsense to me. If you're responsible for status Indians, be responsible for status Indians. If they live in Winnipeg, city

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To summarize, there is some dispute with regard to whether getting the intergovernmental pieces in place is the main stumbling block to effective TB control and prevention. While the federal-provincial health policy landscape is frequently characterized by incessant jurisdictional squabbling, when it comes to Aboriginal health, it seems that there are ways forward that would respect and preserve jurisdictional sovereignty, but they may require the federal government to spell out – in clear terms – its full constitutional responsibilities vis-à-vis Aboriginal health issues.

Democracy

TB immediately invokes issues around the protection of minorities, especially since it is a disease of the marginalized. It also, however, is a classic public health problem because it pits the rights of a minority (those infected with active TB) against the rights of the majority, who is at risk of becoming infected if they come into contact with someone who has active TB. Among many in the Aboriginal community, there remains a distinct determination to avoid complete reliance and dependence on the federal government for health services and delivery, yet at the same time, a parallel desire to avoid a segregated Aboriginal health system. Some interview respondents felt that their specific home province would be better suited to dealing with health protection and service delivery, as opposed to official, bureaucratic Ottawa. There is agreement, however, that improved communication and discussion between all parties in the intergovernmental relationship would be better served by increased commun

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nation) relationships established in the treaties and the division of powers that emerged in these agreements" (Ladner 2003, 174). Abele and Prince lay out several models of a new-found relationship between Aboriginal people and the state, although health, regrettably, is not a primary consideration in their analysis. The one model that might be fruitfully applied to the TB case is "three cornered federalism", which symbolizes formal collaboration among the federal, provincial/territorial, and Aboriginal governments or national organizations" (Abele and Prince 2003, 138).

Although there is a tendency among some federal public health 'boosters' to seek simply an expansion of the federal role and 'damn

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governments to do this, using funds transferred to them by the federal government? How might one assess whether such a transfer of power and authority is actually working on the ground?

Given the attention that has been paid recently to Aboriginal poverty and social problems, and how these exacerbate the already poor health outcomes of Aboriginal peoples, it is surprising to find little in the way of creative thinking in this regard. The closest thing we have seen in recent years is the *Blueprint on Aboriginal Health*, which rolls out an ambitious 10-year plan to close "the gap between the general Canadian population and Aboriginal peoples…" (Blueprint on Aboriginal Health 2005, 2). Prepared by former Prime Minister's Paul Martin's Liberal government in partnership with all of the provinces and territories as well as five national aboriginal organizations representing First Nations, Inuit, Métis, women, and urban Aboriginals, the Blueprint commits to providing health programs and services to First Nations, Inuit and Métis "regardless of

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[1] This study is limited to examining the intergovernmental challenges associated with mounting effective TB prevention and control programs among Aboriginal populations. For the purposes of space, I do not deal with TB prevention programs in immigrant and refugee populations, which indeed pose some unique jurisdictional challenges of their u

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