

# **SPECIAL SERIES: THE ROLE OF FEDERALISM IN PROTECTING THE PUBLIC'S HEALTH**

***Jurisdictional Ambiguity or Lack of Political Will?***

***Intergovernmental Relations, Public Health, and Tuberculosis  
Control among Aboriginals in Manitoba and Saskatchewan***

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## 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.<sup>1</sup> 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 control a public health priority. Although there was some recognition that Aboriginal communities are faced with a number of more pressing health issues, such as diabetes, HIV/AIDS, and suicide, it was suggested that the onus should be on policy makers to 'connect the dots' with regard to the impact of poverty (and inadequate housing) on disease generally, and TB specifically. And, if the poor health outcomes of Aboriginal people were not enough justification for increased policy attention, the nature of communicable diseases such as TB means that such problems will not be confined to Aboriginal communities -- they threaten Aboriginals and non-Aboriginals alike. This is not to suggest, of course, that the only reason to be concerned about TB among Aboriginal people is because of its potential to spread to non-Aboriginals. Rather, it is meant to underscore the fact that this "Aboriginal" problem has important, wider public health implications.

## Methodology

I began with a literature review related to the field of Aboriginal health in Canada, focusing on the policy-related literature that pays specific attention to important jurisdictional issues related to public health in general, and Aboriginal health in particular. Secondly, I examined some of the social scientific literature on the history of tuberculosis, casting the net wider to examine policy responses in different countries, to determine if there are any insights to glean from how other states have dealt with tuberculosis control. Third, we collected relevant federal and provincial government documents relating to tuberculosis, as well any reports prepared by Aboriginal governments and organizations (such as the Assembly of First Nations and the National Aboriginal Health Organization) and non-governmental organizations (such as STOP TB Canada and the Canadian Lung Association).

The second stage of the research involved interviews with key stakeholders in the two provinces chosen (Saskatchewan and Manitoba) to determine how these provinces coordinate the response to tuberculosis in Aboriginal communities or among Aboriginal people who are not living exclusively in Aboriginal communities. Indeed, the latter is a particularly challenging policy problem, since the federal government's responsibility for First Nations and Inuit Health is confined to on-reserve populations. The reality, of course, is that Aboriginal people frequently leave or at least travel outside of their reserve, potentially placing others, Aboriginal and non-Aboriginal alike, at risk of contracting this communicable disease. Finally, interviews were conducted with federal government officials working specifically in the First Nations and Inuit Health Branch on the TB file. Respondents were asked a set of common questions regarding the intergovernmental relationships that have developed in their respective province and what, if any, impediments they viewed prevented officials from engaging in effective TB prevention and control.

### **An illustration of the intergovernmental challenge**

The tangled web of intergovernmental relations as it relates to the health of Aboriginal peoples came to life in 2007 when it was revealed that provincial and federal governments had bickered for years over who would pay for the specialized care required by a young Aboriginal boy suffering from a rare neuromuscular disorder (see Lavalée 2005). The boy, Jordan Anderson, died in 2003 at the age of 4 after being shuttled from a hospital in Winnipeg to a specialized foster care centre close to his home, on the Norway House Cree Nation reserve in northern Manitoba. As MacDonald and Attaran (2007, 321) argued in a forceful editorial in the *Canadian Medical Association Journal*, "Jordan's interests fell a distant second; intergovernmental squabbling over the duty to pay came first" (2007, 321). "It was Jordan's living on-reserve that caused the bureaucracy to choke," they continued. Had he been a white Manitoban or off-reserve Aboriginal, many of the services would have been paid for without hesitation. While the Manitoba and federal governments reached an agreement in 2008 to put in place "Jordan's principle," which commits the parties to set aside jurisdictional squabbling when dealing with

children on reserve who require medical care, the jurisdictional wrangling has by no means gone away when it comes to Aboriginal health issues.

This “jurisdictional swamp” in the Aboriginal policy field is hardly new, however, and it has sparked a range of academic and legal debate. Some of the issues include the Crown’s fiduciary obligation to Aboriginal peoples, the jurisdictional quagmire of urban and off-reserve Aboriginal people, the responsibility for whom is juggled among federal, provincial/territorial and municipal governments (Hanselmann and Gibbins 2005), and the legal status and moral force of generations-old treaties, which Aboriginal people contend should be respected if a better relationship is to be forged between Aboriginal and non-Aboriginal peoples (Boyer 2004).

Admittedly, the distinctive challenges associated with the delivery of health care services and the protection of public health as they pertain to Aboriginal people have received comparatively less attention than the broader governance issues related to Aboriginal-Canadian relations. As far as the delivery of health care is concerned for First Nations and Inuit people, it is difficult to gain a clear picture, not surprisingly since there are competing interpretations offered by federal, provincial and Aboriginal governments with regard to duties or obligations. As far as the federal government is concerned, any health services it provides to First Nations and Inuit living on reserve is done ‘as a matter of policy’ only (Boyer 2004); it does not flow from any legislative responsibility but rather as a matter of last resort. When it comes to physician or acute care services, Aboriginal people are entitled to services just like other residents of that province who are covered under the provisions of the 1984 Canada Health Act. Those costs are generally borne exclusively by provincial and territorial governments.

The federal government is directly involved in providing specific funding for a raft of public health initiatives through a series of contribution agreements, many of which are delivered on reserve only. The Tuberculosis Elimination Strategy is one example, while others include the Fetal Alcohol Spectrum Disorder program, as well as chronic disease and injury prevention programs. Exceptions include the Aboriginal Diabetes Initiative, which is offered to both on- and off-reserve status persons.

Health Canada’s First Nations and Inuit Health Branch (formerly the Medical Services Branch) also delivers supplementary “medically necessary” health care services to status persons, whether they live on or off reserve, through its Non Insured Health Benefits (NIHB) program, the goal of which is to raise the standard of living of Aboriginal people in line with non-Aboriginals. Services covered under the NIHB include, among others, prescription drugs, eyeglasses, medical equipment and dental care, and medical transportation for those living on-reserve and in traditional territory (Inuit).

**Table 1: Overview of Federal Services**

<b>Programs targeting all Aboriginal people</b>	<b>Non-insured Health Benefits Program for all eligible First Nations and Inuit</b>	<b>* Programs available on all First Nations reserves and Inuit communities in Labrador</b>	<b>Programs available only in isolated and remote communities</b>
- Limited prevention and promotion programming (eg: Aboriginal Diabetes Initiative, National Aboriginal Youth Suicide Prevention Strategy)	- Vision care - Dental treatment - Drugs - Crisis mental health counseling - Medical transportation** - Medical equipment and supplies - Provincial health premiums	- Prevention and promotion programs - Public health - Alcohol/drug - addiction treatment - Home and community care	- Primary care nurses (assessment diagnosis, drugs for acute care and referral to other health care services) - Emergency services

Source: Adapted from Paula-Hadden Jokieli, First Nations and Inuit Health Branch, Community Programs Directorate, March 2008.

\* Depending upon the community in question, some of these programs may be eligible for transfer directly to the community under the Health Transfer Policy, which was designed to give First Nations and Inuit (in Labrador only) greater control over programs and services.<sup>2</sup>

\*\* The federal government is responsible for First Nations status person living on reserve or off reserve for less than three months, as well as Inuit living in traditional territory. The provincial government picks up the tab for Métis, FN non-status and status living off-res for more than 3 mo, as well as Inuit living outside of traditional territory.

Provincial governments, for their part, generally argue that the responsibility for health care services to First Nations and Inuit people living on reserve is a federal one. Aboriginal governments and constitutional/legal scholars argue quite forcefully that Aboriginal people are entitled to health care services as a matter of right, pointing to the guarantee they believe is contained in the 'Medicine Chest' clause found in Treaty Six. Others would point to the Indian Act as further proof that the federal government has obligations to registered Indians.

In some cases involving public health problems, notably communicable diseases, the federal government's refusal to include off-reserve populations can impose additional burdens for provincial and territorial governments who would be expected to pick up the slack, just as they would for other residents, whether Aboriginal or non-Aboriginal. This is made all the more pressing with the recognition that Aboriginal populations are fairly mobile, frequently migrating on and off reserve.

And, to complicate matters further, there is a greater recognition that the delivery of health care services in Aboriginal communities – not to mention public health interventions - requires sensitivity to approaches that are culturally appropriate. This means that governments, whether they like it or not, need to actively engage the communities in question, which can be challenging given the legacy of colonialism vis-à-vis Aboriginal peoples. This is only made worse in the case of TB by the fact that this highly stigmatizing disease killed many Aboriginal people who were housed by the federal government in residential schools across the country that sought to extinguish the residents' Aboriginal identity and culture. The residential schools' legacy was revived in 2008 with the federal government's recent apology to Aboriginal people, and with the creation of a Truth and Reconciliation commission to address the lingering effects of the residential schools saga.

### **Tuberculosis as a Public Health Threat**

Tuberculosis has long been steeped in historical meaning since it was first identified several centuries ago. For years it was regarded as a 'romantic' disease, a disease of the creative classes, itself not surprising given the fact that a number of artists, poets and literary figures had contracted the illness, including writers Franz Kafka and D.H. Lawrence, and the celebrated composer Frederic Chopin. At the time, the tubercular 'look' had become almost chic, fashionable: "For snobs and parvenus and social climbers, TB was one index of being genteel, delicate, sensitive" (Sontag 1989, 28). It is difficult to imagine how tuberculosis could be transformed from being an illness one wore as a badge of honour, as an expression of one's "superior sensitivity", to a dreaded disease of poverty and deprivation, and a potent reminder of the crippling effects of illnesses with strong socio-economic determinants.

Despite a host of advances in treating a number of public health threats, tuberculosis continues to elude the public health community in the developing and developed worlds. The World Health Organization has identified its eradication as a key priority, as has the G8, in a 2001 summit declaration of which Canada was a signatory. Although the number of TB cases in the general population has dropped significantly in Canada, it continues to be an important concern for "high-risk" groups, including newcomers to Canada and members of First Nations, Inuit and Métis populations. Although there is some disagreement in the literature as to the exact degree, it is generally accepted that Aboriginal people are disproportionately affected by TB, with rates among Aboriginals anywhere from five to ten times the rate of non-Aboriginal Canadians. In the early 20<sup>th</sup> century, an epidemic of TB spread throughout many First Nations communities, with death rates as high as 700 per 100,000. During the 1930s and 1940s, TB death rates

among Aboriginal children who were housed in residential schools were in upwards of 8,000 per 100,000 (First Nations and Inuit Health Branch, Health Canada, website).

In many ways, TB can be viewed as the “quintessential public health disease”, as its “pathogenesis and transmission are inseparably linked and because it thrives wherever conditions of poverty, overcrowding and ignorance exist” (Long 2002: 264). Today, one is more likely to frame the discussion of TB prevention in terms of the ‘social determinants of health’. That is, improving the socio-economic conditions in which marginalized communities live is seen as a wise and effective way of tackling a disease such as TB, which thrives among populations affected by poverty, overcrowded housing conditions, homelessness, poor nutrition, and the presence of other illnesses, such as Type 2 Diabetes or HIV/AIDS. Also known as “consumption” or the “white plague”, TB infection has been associated with increased mortality rates among HIV-positive people.

What frustrates public health advocates the world over is that several strains of TB are relatively easy to diagnose and treat, even though the drug regimen can be intense, requiring patients to take three to four drugs concurrently for at least six months. High failure rates due to non-compliance led the World Health Organization to recommend Directly Observed Therapy (DOT), which, as its name implies, involves the direct supervision of patients consuming their medication to ensure proper compliance. Up until the 1950s, people with active TB were housed in sanatoria. At its peak, there were 19,000 beds across Canada for people suffering from tuberculosis.

As if it weren't difficult enough to cope with the TB problem, new strains of TB have emerged recently that are resistant to drugs. For instance, multi-drug resistant TB is resistant to at least two of the main first-line TB drugs. One study of TB samples by the US Centers for Disease Control and the World Health Organization found 20 per cent of them to be multi drug resistant. Recently, even more resistant forms of the mycobacterium have been identified. XDR (extensively drug resistant) TB, which is virtually untreatable, has been identified in numerous regions including the U.S., Eastern Europe and South Africa. XDR TB is resistant to both first- and second-line drugs.

The highly infectious nature of TB also raises important ethical questions regarding the appropriate government responses to prevention and treatment, questions that must be grafted alongside the jurisdictional ambiguities associated with health care and public health interventions in the Canadian context. Should states, for instance, put in place measures to involuntarily detain people with certain forms of TB from mixing with the general population? And what is a reasonable period of time to be held in isolation, given that a diagnosis of extensive or multi drug resistant TB can take weeks to confirm? Singh, Upshur and Padayatchi (2007) have criticized the WHO's strategy of “allowing the patient to assume responsibility for mixing with the greater public” as too permissive, but they stopped short of supporting the “forcible treatment” of patients with highly drug resistant forms of TB (2007, 0004).

As historians of medicine and others have made clear, historically, state responses to tuberculosis have been complicated by dominant constructions of who it affects, namely marginalized people, including homeless persons, immigrant populations, and Aboriginal people. Due to its infectious nature, people with tuberculosis have been subjected in the

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 Aboriginal communities by the legacy of colonialism and the saga of residential schools, which became virtual breeding grounds for infection as government after government stood by and failed to intervene. Beyond the brutal conditions and decades-old attempts to exterminate Aboriginal culture, there were epidemics of TB among many of the children housed in these schools. One study of children in residential schools in Western Canada found that one in four had died of TB over a 14-year period. Archival data that has surfaced suggests that children were deliberately exposed to other children with active TB in the hopes of “toughening them up”. An investigation by *The Globe and Mail* revealed that many sick children ended up dying in residential schools because of a federal government policy that compensated churches on a per capita basis to run the schools: “Because of this funding policy, churches would admit sick children and refuse to send ailing ones home. Pleas to the department for more funding fell on deaf ears” (Curry and Howlett 2007, p.A1, A14).

In the early 20<sup>th</sup> century, tuberculosis became a “metaphor for Aboriginal-European contact and for the presumed fate of Aboriginal people.” As Waldram et al. explain, the “Red Man and the White Plague” was seen as a “kind of relentless process of nature, like an earthquake that we could stand in awe of, and be very sad about but do nothing to check or change” (Stewart quoted in Waldram et. al. 1995, 263). It was not long before others sought explanations or rationales for the apparent inability of Aboriginal people to fend off this White Plague. One powerful explanation was racial susceptibility to particular diseases, which sat well with the prevailing view in the 19<sup>th</sup> and 20<sup>th</sup> centuries that race could explain human biological variation. In this view, “the inability to mount an effective immune response to particular diseases was one of the features thought to distinguish ‘primitive’ from ‘civilized’ races” (Waldram et al. 1995, 263). The “prescription for good health” that was advanced at the time by one of the country’s leading medical authorities on tuberculosis was “that Native people would only gain the good health enjoyed by non-Native Canadians when they ceased being Native” (Lux quoted in Boyer 2004, 13).

Public health efforts to prevent and treat disease are weighed down by the colonial relationship that has characterized Aboriginal-non Aboriginal relations since the arrival of the Indian Act in 1876. Indeed, one informant was blunt, identifying the Indian Act as the main impediment to effective TB control efforts among Aboriginal people. “I think they should take the Indian Act and burn the goddamn thing. Sorry. I think the Indian Act is, in my view, a hindrance to any progress. Instead of tampering with it, and they continue to say they’re going to do something and they never come up with a new Act or never pass it, get rid of the damn thing” (Informant, Winnipeg, Manitoba, August 2005). It is worth pointing out, however, that the federal government has tried, in the past, to



“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, or the private sector. But these divisions are *superficial* in the light of the health system as a whole” (Health Canada website, “Indian Health Policy”, italics added). The federal government identifies its most significant role in this ‘interdependent’ system in terms of public health activities on reserve, health promotion and the detection of hazards to health in the environment.

Provincial departments of health “are responsible for insured health services provided to both registered and non-registered FN (First Nations), regardless of whether they reside, on or off reserve, and for Métis and non-Aboriginals” (Orr et al. 2007, 300). For some, the federal government’s reluctance to accept any formal legislative responsibility for the health of Aboriginal people, whether they live on or off reserve, reinforces the ambiguity surrounding who is exactly responsible for what. And the addition of pressure to recognize the inherent rights of Aboriginal people to manage their own nations means that, in some cases, respect for sovereignty can become a convenient cover for inaction.

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 jurisdictional issues" were singled out as undermining "the ability of First Nations and Inuit people to reasonably access services" (Lavoie et al. 2005, 12). It is important to stress here that even under a transfer process, FNIHB requires that certain programs be in place, namely communicable disease control, environmental health, and emergency response. For the purposes of tuberculosis, the role of the Medical Officers of Health (MOH) is most relevant. While their roles may vary from one jurisdiction to another, generally the MOH handles immunizations and oversees health surveillance and any communicable disease outbreaks, as well as screening for a number of communicable diseases, including TB. Some First Nations object to the fact that medical officers of health employed by First Nations bands are subject to the legislative authority of the provincial and territorial governments in which they operate, and not to First Nations laws and policies.

First Nations claim the same type of jurisdiction over health as the Territories. Both exercise jurisdiction delegated by the federal government, which is not based upon the Constitutional division of powers. Moreover, First Nations also claim jurisdiction over the health of First Nations pursuant to an inherent right to self-government, which has been recognized by the Royal Commission on Aboriginal Peoples and the federal government. In addition to jurisdictional entitlement, the Crown-Aboriginal fiduciary relationship, which includes the duty to consult, First Nations feel mandated to take part in planning and policy, as it affects First Nations health. Given that the 2003 First Ministers' Health Accord and the Kelowna Accord, not to mention the Romanow report called for increased Aboriginal and non-Aboriginal collaboration in health matters, among other things, there is, at least, a moral commitment to include First Nations at the table during inter-governmental meetings.

While the federal government's legislative authority in public health matters and with respect to Aboriginals is clear, the federal government maintains that provision of health services to Aboriginals is done as a matter of policy only and not because of any fiduciary obligation, or Aboriginal or treaty right (Commission on the Future of Health

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.

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 communities; urban Aboriginal people have difficulty obtaining access to provincial programs available to other urban residents; and urban Aboriginal people would like access to culturally appropriate programming” (Graham and Peters 2002, 18). Unfortunately, there is little discussion here with respect to health care services, although one might conclude that such services would fall under the umbrella of culturally appropriate programming.

What is perhaps most instructive, Hanselmann and Gibbins argue, however, is the degree of “informal intergovernmentalism” that is occurring: “although there is no formal agreement over primary responsibility for urban Aboriginal policy and no regularized intergovernmental mechanisms for the exercise of shared responsibility, this has not prevented federal and provincial governments from taking the initiative on this policy file” (2005, 84). Others have referred to this as a form of “instrumental federalism” – intergovernmental arrangements that get things done. As Phillips explains (2001, 3) with reference to the 1999 Social Union Framework Agreement (SUFA):

Instrumental federalism is a new approach to intergovernmental relations in several respects. First, it is an attempt to focus on problem-solving, or as the federal government sees it, “doing what works for Canadians,” without being unduly hampered by jurisdictional boundaries. Second, perhaps even more essential than actually fixing policy problems is being seen to do so, in part by involving citizens in the policy process. The third and potentially most important element of instrumental federalism is accountability through outcomes-based measurement and public reporting. Under this new regime, citizens become the third force of federalism — not so much as a means of truly reducing the democratic deficit, but as an indirect vehicle for governments to hold each other accountable, something they cannot do directly in our federal system.

To summarize, while somewhat complicated and subject to competing legal and constitutional interpretations, the responsibility for the health of Aboriginal people is still largely determined by their status and their place of residence. The First Nations and Inuit Health Branch is active in a number of specific initiatives targeted to on-reserve First Nations and Inuit people, much more active than government officials are inclined to acknowledge. Some of these programs and services are offered directly, while others have been transferred to the communities themselves, but the situation varies from reserve to reserve, community to community. As noted earlier, the federal government also funds, through its Non Insured Health Benefits Program, a range of supplementary programs and services for registered Aboriginal people, regardless of whether they live on or off reserve.

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, regardless of their status or where they live within the province. The only exception is First Nations and Inuit who live in remote or isolated communities, who may have their health care services delivered and/or paid for by the federal government because of issues of limited access.

## **TB Control amongst Aboriginals in Canada**

It was not until 1992 that the federal government recognized the importance of developing a coordinated strategy to attack TB in the Aboriginal population. With the cooperation of representatives of the federal, provincial and territorial governments as well as the Assembly of First Nations, the main advocacy group for First Nations, a National Tuberculosis Elimination Strategy was developed. The strategy sought to reduce the number of TB cases in Canada to less than 1 case per 100,000 per year among Aboriginal people by 2010. This has since been revised to a target of 3.6 per 100,000 by 2015. While the overall risk of TB has decreased from 80 cases per 100,000 in 1990 to 30 per 100,000 in 2000, the risks are not necessarily evenly distributed as more than a third of the total TB cases among Canadian-born Aboriginal people could be traced to 10 communities throughout the country (National Advisory Committee on Immunization 2004, 2).

According to the Strategy, all TB programs should include:

- Case finding and directly observed therapy
- Contact tracing and treatment of TB infection
- Surveillance
- BCG vaccine immunization, in communities where use of the vaccine has been recommended
- Health education, training, and research

Provincial and territorial tuberculosis control programs participate in a national tuberculosis surveillance system, known as the Canadian Tuberculosis Reporting System. Information on new active and relapsed cases of TB is reported from the provincial and territorial case registries to Health Canada, which publishes data in an annual report on TB. First published in 1995, following transfer of responsibility for surveillance from Statistics Canada, data were provided according to province/territory, type of TB, bacillary status, age, sex, ethnic origin and birthplace.

TB control in Canada is governed by two models: “a centralized control program that includes the provision of clinical services, and a program that has both centralized and decentralized public health elements but relies on community-based specialists and primary care physicians for the delivery of clinical services” (Naus and Enarson 2000, 169-170). The authors note that the first model, which developed as a result of the sanatorium system, can be found in B.C, the Prairies and the territories, with the second model more common to Ontario, Quebec and the Atlantic provinces. In both models, the

responsibility for public health is divided among regional, provincial/territorial and federal levels of government. To this, we would add, in the case of TB among Aboriginal populations, various Aboriginal orders of government, as well, in addition to non-profit organizations such as the provincial lung associations, and the Sanatorium Boards, which played a pivotal role up until recently in Manitoba. In 2006, Manitoba Health (the provincial government department) announced that it was taking over the Tuberculosis Control program from the Sanatorium Board of Manitoba, which ran the program for several decades. The new program structure “will help health-care officials co-ordinate the use of existing health-care resources and will integrate tuberculosis case management with current public health operations”, the Department said in a short statement (Manitoba Health, News Release, April 28, 2006).

With regard to public health infrastructure for TB control, legislation in all provinces and territories that require reporting of cases of active TB to local public health agencies. This local-level data normally makes its way to a national reporting system, usually via a provincial or territorial database. Although the confidentiality of the data is protected, “public health legislation provides for powers to ensure that suspected or confirmed cases of active pulmonary tuberculosis receive timely diagnosis and treatment” (Naus and Enarson 2000, 170). While public health officials normally seek to obtain voluntary compliance with respect to treatment, “legislation allows for involuntary detention for diagnosis and treatment where compliance cannot be obtained, as might be the case in serious psychiatric conditions or alcohol abuse” (Naus and Enarson 2000, 170).

Unlike other communicable diseases, tuberculosis control, as a result of its long case management, requires a distinct set of policies and procedures. For instance, the recommended treatment for persons with active tuberculosis, Directly Observed Therapy, entails a strong commitment to health human resources, since individuals need to be physically monitored to ensure compliance. In addition to this, public health staff must develop strong relationships with primary care and other physicians, as well as develop relationships with agencies or partners that can provide psychosocial services to help individuals address and overcome barriers to treatment compliance. Moreover, the increasing incidence of individuals with tuberculosis who might be co-infected with HIV requires some integration with HIV/AIDS programs operating in the respective area, as well (Naus and Enarson 2000, 172). (People with advanced HIV infection are vulnerable to a wide range of opportunistic infections that attack their weakened immune systems; TB is thus a common cause of death of people living with HIV.)

As regards operational activities, Naus and Enarson identify the setting of goals and objectives, program planning, implementation and evaluation, analysis of surveillance data, and case management. Public health officials, the authors note, are responsible for suggesting program outcomes and processes, and for advocating for continued funding for tuberculosis programs. The presence and analysis of surveillance data is important here, as it can help to bolster the case for continued or increased funding for TB programs targeted at specific high risk populations, such as Aboriginals or homeless people. As they conclude (2000, 173-174):

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.<sup>3</sup> 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 government" (National Advisory Committee on SARS and Public Health 2003, 48). As is evident in the real world of health politics, these types of exchanges occur voluntarily and depend upon on the good will of officials. That being said, one can imagine instances

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 is 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 interactions within two provinces, Saskatchewan and Manitoba. The provinces were selected because they have a significant Aboriginal population, and because they have fairly high rates of tuberculosis among their Aboriginal communities. The provinces should not be regarded as representative, however, of “good” and “bad” ways to deal with the challenges of intergovernmentalism in the field of public health. Each is unique in terms of the



circumstances surrounding the history of TB control and prevention. Manitoba, for instance, was known for the strong presence of a non-profit organization, the Lung Association, in the history of TB in that province. Moreover, as interviews with key informants demonstrate, interpersonal relations between federal and provincial government officials matter, as do relations between and among government officials, public health personnel, and leaders of Aboriginal communities. While it may be problematic to rely on interpersonal relations to dictate how policy is derived, it would be foolhardy, as well, to suggest that codifying a set of rules and obligations will resolve all of the problems that animate the world of intergovernmental negotiation.

### ***Saskatchewan***

Saskatchewan is home to about 141,000 people of Aboriginal ancestry, including First Nations and Métis, according to the 2006 Census, of whom about one third (roughly 47,000) are scattered across more than 450 reserves throughout the province. This represents almost 15 per cent of the total population of Saskatchewan, the second highest in the country behind Manitoba.

As regards public health in general, the province is organized around Regional Health Authorities, which are overseen by elected boards that are responsible for the provision of all health services within their defined area. The Athabasca Health Authority in northern Saskatchewan is the only authority that manages health services for First Nations people living both in and away from First Nations communities. However, the health authority relies on outside provincial agencies for Medical Health Officers and Environmental Health Officers (Assembly of First Nations 2006, 26).

In Saskatchewan, most direct federal expenditures are provided to the province's First Nations through Health Canada's First Nations and Inuit Health Branch. More than half of the Branch's annual spending goes to providing insured health services (52 per cent), with most of the remainder going to support the Non-Insured Health Benefits (NIHB) program. This program takes care of health-related services for First Nations residents in Saskatchewan, and in all provinces and territories, that are not covered by the medicare system, including drugs, medical transportation, dental care, vision care, and mental health counselling. In 2003–04, NIHB expenditures comprised roughly 35 per cent of all direct federal health expenditure in Saskatchewan (Marchildon and O'Fee 2007).

Funding for the National Tuberculosis Program is centralized at the national level, "to prevent the loss of dedicated funding to Regional TB program, and to allow for changes in funding allocations to Regions as trends in TB epidemiology change over time. TB services in Saskatchewan are delivered by three central authorities in Saskatchewan region, which cover the northern, central and southern areas of the province. There is some degree of centralization at the regional level in the areas of drug procurement and supply, case management and TB registry and surveillance activities (Health Canada 1999, 25). The program works in collaboration with the regional office of the First Nations and Inuit Health Branch, the University of Saskatchewan, and Saskatchewan Health. In the late 1990s, a TB nursing program in the northern region was transferred to a tribal authority. While "it was difficult for central TB control to let go of many

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 government to arrange the delivery of services to six First Nations communities in extremely remote settings where non-First Nations communities were in close proximity and receiving duplicate services by the province. In return for the province providing services to these six communities, the federal government provides services to non-First Nations living in First Nations communities” (Assembly of First Nations 2006, 27).

Public health is governed by two different authorities in the province. A Chief Medical Officer of Health oversees new and emerging public health issues while the communicable disease and legislative side of public health is governed through a Director of Public Health. Both of these positions report to the Deputy Minister of Health. The Chief Medical Officer of Health does not have direct responsibility for any specific program but all of the provincial Medical Officers of Health report to the Chief Medical Officer of Health.

Like Saskatchewan, the province has 11 Regional Health Authorities. The provincial department of health includes an Aboriginal Health Unit, which is supposed to “function as a voice for Aboriginal peoples in Manitoba living away from First Nations communities” (Assembly of First Nations 2006, 27). In addition, there are a number of clinics and health centres that serve First Nations, albeit not exclusively. Funding for these centres is provided through a patchwork of partners, including Health Canada, Manitoba Health, Healthy Child Manitoba, the Aboriginal Healing Foundation, and the United Way.

In Manitoba, TB control services had been delivered exclusively for several decades by the Sanatorium Board of Manitoba in this region. The Board had been kept busy over the years dealing with a number of outbreaks, especially in northern remote communities. In 2006, the Manitoba government announced that after decades of operating their Tuberculosis Control program through this independent agency, it had decided to integrate the program with provincial communicable disease programs.

## 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 on-reserve status Indians, leaving the province to pick up the tab for off-reserve Indians (with the exception of the federally-funded Non Insured Health Benefits program, which is available to off reserve Aboriginals). It is difficult, however, to fit the TB case into this model, especially given the complexity and the number of actors at the table, including not only federal, provincial and municipal governments, but regional health authorities, Aboriginal governments, and non-profit organizations.

Public health, as it affects First Nations living on reserve, falls under the responsibility of the federal government. Section 66 (3) of the Act is clear in stating that “The Minister may authorize the expenditure of revenue moneys of the band for all or any of the following purposes” including “to prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable” in addition “to prevent overcrowding of premises on reserves used as dwellings”. The latter would address the issue of housing density and the evidence linking increased housing density to the spread of TB. (*Indian Act*, pp. 44-45, available at: <http://laws.justice.gc.ca/en/ShowFullDoc/cs/I-5///en>).

It is important to stress, however, that the First Nations and Inuit Health Branch is fairly guarded with respect to its role in delivering health services on reserve, and does not refer to the existence of the Indian Act as evidence of a commitment to providing care. This might explain why it normally refers to its activities as strictly a “matter of policy”, and not flowing from any legislative commitment. Certainly, the same can be said of public health activities benefitting non-Aboriginals, since there is no specific federal role spelled out in this regard.

The nature of the current relationship between the federal government and Aboriginal governments is characterized by some form of interdependence. The ability to develop an effective TB policy on reserves is dependent on an interaction between federal health officials, their provincial counterparts as well as Aboriginal leaders. In the case of TB, the federal government is hampered by the lack of any federal public health legislation that applies to reserves. The relationship could also be described as non-hierarchical, in the sense that the federal government is operating within its own constitutional jurisdiction, supported by legislation including the continued existence of the Indian Act. Aboriginal people might bristle at the suggestion, however, that relations between them and the federal government are non-hierarchical given the existence of the colonial Indian Act. The problem might stem, as well, from my own understanding of “hierarchical”, which differs somewhat from how it is defined by Wilson and Lazar for the purposes of their classification system.

However, the relationship is also potentially coercive with the federal government having the ability to influence Aboriginal policy through federal actions, or perhaps more importantly, through inaction. In the latter scenario, the federal government’s failure to take appropriate measures to address the problem of TB on reserves may require a policy

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-hierarchical (a collaborative relationship). Unlike the case of health care more broadly where the federal government is able to attach conditions contained in the Canada Health Act to its transfers to the provinces (interdependence coupled with a hierarchical relationship is referred to as federal unilateralism), in this area, the federal and provincial governments are in constant negotiation about who is responsible for what and where the buck stops, despite the fact that from the perspective of each government, the lines of authority are clear. And it is important to underline that when it comes to public health, the federal government is quick to point out in its literature, that there is no federal public health legislation that applies to Aboriginal communities; public health acts are provincial. There is some dispute about whether the Indian Act, which applies to all reserves, might trump a provincial public health act, because it justifies a range of interventions in the name of protecting the health of those living on a reserve. While this relationship can be harmonious at times, the tag “collaborative” should not be confused with the idea that all parties are getting along at all times.

In addition to the complex intergovernmental relationship vis-à-vis public health and health care, one must add to the mix other policy fields, namely social policy, since TB is an important example of a disease with strong, underlying socio-economic determinants. Therefore, acting on social policy might be seen as part of a broader, indeed progressive, “healthy public policy” response.

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 incidence of TB to the targets identified in the original document. As noted earlier, the targets were modified recently. In terms of its impact on the health of Aboriginal populations, the main policy in question (the Tuberculosis Elimination Strategy) has never been evaluated, either from a cost benefit analysis or cost effectiveness analysis, even though it is more than a decade and a half old. Therefore, it is difficult to tell whether it is working. Using reduced incidence as a benchmark would suggest that indeed, TB incidence has dropped significantly from the residential schools era alluded to earlier, when death rates from TB were appallingly high. But it is not necessarily surprising, however, that rates would drop significantly following the closing of residential schools. The decrease that is being attributed to the TB Elimination Strategy may have everything to do with policy decisions to shut down residential schools, and very little to do with actual policies to prevent and control TB among Aboriginal populations. Given the fact that social determinants perspectives are almost axiomatic among even the most neoliberal of governments, the lack of such an

approach is a glaring omission, given the overwhelming evidence that health is structured by these determinants, in this case by socio-economic status and, relatedly, access to adequate housing.

In 2005, a report commissioned by the First Nations and Inuit Health Branch suggested that more realistic goals be set with respect to TB in Aboriginal populations. Although the elimination of TB remains the ultimate goal, the report recommended that a new goal be set of reducing TB incidence to 3.6 per 100,000 population by 2015 (Orr et al. 2007, 304). While mention has been made of jurisdictional squabbling in other areas related to public health – indeed the Assembly of First Nations has written an exhaustive report on the subject of public health – there has been little attention to these issues in the context of TB. This may be related to the fact that the majority of attention to TB has been centered on issues related to treatment adherence and epidemiological studies of TB incidence in various sub populations, including Aboriginal people, the homeless, and the foreign born.

The policy effectiveness of the intergovernmental relationship is a challenge to assess, in part because it is difficult to isolate the main reasons why the Tuberculosis Elimination Strategy has failed to reach the targets it identified more than a decade ago. The ability to create a program to improve TB control is often stymied by the various jurisdictional levels capable of blocking progress and initiatives. As many Aboriginal health initiatives must draw on at least two different funding sources, the possibility of community based plans being steamrolled remains high. Some respondents were particularly concerned about the urban/reserve split, which was perhaps not surprising given that the two provinces have cities (Saskatoon, Regina, and Winnipeg) with significant Aboriginal populations. While analysts of federalism have been eager to include cities as a ‘third force of federalism, municipal/local governments seem to be largely absent in planning or consultation on TB even though large numbers of Aboriginals live off-reserve in urban centres such as Winnipeg and Saskatoon.

Policy effectiveness has also been hampered by personality clashes in some cases, which can frustrate attempts to coordinate and share information and expertise effectively. For instance, the tradition had been for the TB control office to work directly with FNIHB and not with the provincial department of health:

In the past there was a TB program in Winnipeg which did not form or hold partnerships with urban areas such as Thompson and Winnipeg. There was almost no interaction between the TB control program and public health people either in Thompson or Winnipeg. There was very little cooperation or communication or sharing of workload. There was a highly centralized program in the TB control office which did not form these partnerships I’m talking about, and so now when the TB control office is saying not only would we like these partnerships, but they’re mandatory, and that the previous control program was not able to do the required control work to a standard of care which was required, the Department of Health is – is not stepping up to the plate to create the partnership required to put in the resources required for that. Why don’t they? I think they don’t realize the enormity of the problem. I think they don’t understand that standards of care that

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 of Winnipeg has to pick it up. Or Brandon, or Thompson, or where ever. To me, that's silly. The federal government says, "Well, these are the treaties and we're responsible to provide health care on-reserve for status Indians. They go back and forth all the time.

In both provinces, it is a testament to its utter complexity that it is extremely difficult to get a handle of the basic framework under which TB control operates with respect to Aboriginal populations. At the very least, we need to move beyond a form of "add-on federalism" that would represent Aboriginal governments as simply another order of government in a world of multi-level governance. Although legislative authority of the federal government vis-à-vis public health does not differ from province to province, how (and if) provinces interact with the federal government does. And this often depends upon the inter-personal relationships that have developed – or not. Indeed, inter personal relationships seem to figure prominently in the disagreements over the direction of TB control in Manitoba, with the current director of TB control fairly critical of her predecessor's centralized approach.

The perspective expressed by some Aboriginals is that the federal government does not respect the jurisdictional sovereignty of First Nations, because there is still an "imposition" on First Nations authority through funding allocations and a lack of clear responsibility throughout the various levels of government that coordinate public health service delivery for Aboriginal peoples. More challenging is the necessity for provincial First Nations to identify priority health areas to tap into various funding allocations and programming – yet in a province like Manitoba, with 63 First Nations, a collective priority list is next to impossible to achieve, given the unique geographic, jurisdictional and political environment in which most communities find themselves. Some Aboriginal respondents believe that there must be First Nations-distinct approaches to public health and economic development issues through all levels of government, from local to federal. As it stands, this does not yet exist in the two provinces.

Finally, while public health legislation in each province and territory charges Medical Officers of Health with powers to protect all citizens, including First Nations living on reserve, from communicable disease, sometimes there is a lack of clarity with respect to who is covered by the Act:

I think it could be clearer. I'll give you an example. When the Public Health Act has to be enforced, I usually phone the Medical Officer of Health for FNIHB and then they tell me to phone the Medical Officer of Health for the province. So I guess it's clear to me now because I've been told, but that enforcement of the Public Health Act on-reserve is the responsibility of the MOH for the province... But when I read the Public Health Act, it wasn't really clear to me. You know, it didn't actually say on-reserve or off-reserve (Informant, Winnipeg, August 2005).



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 community involvement. Part of this would entail better engagement of issues like TB control by Aboriginal leaders as some interviewees pointed out. Without the political mobilization of Aboriginal constituencies (and improved communications between those Aboriginal constituencies), obtaining positive government cooperation with various Aboriginal communities will remain an ongoing challenge, especially when TB struggles in the shadow of other, more pressing health issues, such as HIV/AIDS, addictions, and diabetes, to name a few. There is also a need, however, for all stakeholders to find a middle ground between a singular focus on determinants of health (poverty, housing, etc), which has been the rallying cry of Aboriginal leaders in, for instance, the Assembly of First Nations, and the government focus on surveillance systems. Not surprisingly, for many in the Aboriginal community, preventative measures are preferred to surveillance “after the fact”, but it is not wise to ignore completely the potential of surveillance mechanisms in the fight against TB, within and outside of Aboriginal communities. In addition, while there are some strong examples of community-led initiatives and leadership in Aboriginal communities vis-à-vis health, self determination in the field of public health should not be regarded as a panacea either. While the Assembly of First Nations (2006) is correct to point to the need for a First Nations Public Health Act and a Medical Officer of Health to deal specifically with First Nations public health issues, the nature of public health, and communicable diseases more specifically, requires that we widen the scope of our interventions beyond a particular community.

The form of federalism that would be best suited to address the democratic issues raised by public health interventions in the health field would require a full consideration of how existing Aboriginal rights – including their legal interpretation – affect the level of government commitment to health care services. Some Aboriginal scholars refer to “treaty federalism” as one possible option, which is defined as the “federal (nation to

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 the provincial torpedoes’, Naylor cautioned in his report against such a course of action: “Attempts at unilateral centralization of authority in a fragile federation with a complex division of powers and responsibilities are generally a prescription for conflict, not progress. Measures to create collegiality, consensus, and commonality of purpose can lead to collaborative work that overcomes jurisdictional tensions” (National Advisory Committee on SARS and Public Health 2003, 80). Moreover, doing so in the context of an already strained relationship between the federal government and Aboriginal people, could lead to even greater tensions than we are currently witnessing. As one Manitoba informant put it, “Diseases don’t wait for transitional infrastructure to catch up and be in place before they become epidemics... SARS isn’t going to wait until the Public Health Agency (of Canada) has got everything in place for improved surveillance before it comes back. Or the next influenza epidemic isn’t sort of saying, ‘okay you’ve got until 2008’”.

### **Relevance of Findings to Public Health and Federalism**

How does the existing set of intergovernmental relationships contribute to this situation? The lack of clarity with respect to roles and responsibilities can be disastrous when it comes to public health emergencies, as there is a limited window during which to act. If all of the sides are bickering with regard to who is responsible for what, it can result in critical delays before action is taken. If the health of Aboriginal populations were not enough to merit serious reflection on resolving these disputes, the failure to view public health issues in a seamless manner – that is, the failure to view public health on reserve as connected to public health off reserve – means that there are very real threats to the health of non-Aboriginal populations, as well. The danger of moving toward a transfer model – devolving authority to Aboriginal communities – is whether there will be enough federal and provincial oversight and support to ensure that public health problems such as TB are viewed as “public” health problems requiring coordinated action, not a patchwork approach.

This case reveals the extent to which little thinking has engaged the question of how public health interventions might coincide with the governance issues that mark the relationship between Aboriginal peoples and the Canadian state. While there has been no shortage of thinking vis-à-vis how one might imagine a new relationship between Aboriginal peoples and the state, the work of scholars interested in how federalism affects jurisdictional issues related to Aboriginal self government, have failed to reflect on how health, and public health specifically, might figure into this equation. Would, for instance, self-governing Aboriginal nations assume full responsibility for health care and public health prevention? Would they partner directly with provincial and or local

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 their relationship to the Indian Act and regardless of their place of residence (urban, rural, remote, arctic regions, on-reserve or off-reserve” (Blueprint on Aboriginal Health 2005, 4). Although no specific mention is made of tuberculosis, there is a distinct emphasis placed in the blueprint on addressing the social determinants of health, including housing, education and environmental issues.

## **Conclusion**

It is difficult to extract solely the public health dimensions of this case as it is complicated by the nature of the target population. Aboriginal people, especially on-reserve status Indians, have a distinctive, centuries-old relationship to government. The fact that this case involves overlapping policy fields – public health policy and Aboriginal policy – makes it difficult to disentangle the public health dimension of this case from those related directly to Aboriginals. And to complicate matters further, the communicative nature of TB means that it is wrongheaded and indeed dangerous to view TB in Aboriginal communities strictly as an “Aboriginal” problem. It takes very little to turn an isolated outbreak in an Aboriginal community to one involving Aboriginals and non-Aboriginals alike. It is important to stress, however, that the possibility of TB affecting non-Aboriginals should not be viewed as the main reason to get serious about TB. The situation in Aboriginal communities is serious enough to warrant the careful and sustained attention of governments at the federal, provincial and Aboriginal levels.

This case does, however, underline a number of problems with the current approach to dealing with TB prevention and control in Aboriginal population. First, it is surprising, given the volume of attention paid to the social determinants of health for non-Aboriginals and aboriginals alike, that little attention and resources are being devoted to addressing these determinants and the impact they have on TB incidence in the first place. As noted, numerous studies have demonstrated a strong link between housing density and TB prevalence in Aboriginal populations. This case also highlights the need to examine the wisdom of treating reserve and off-reserve populations separately, especially since Aboriginals, notably in provinces such as Manitoba and Saskatchewan, are a notoriously mobile population. Indeed, the responsibility for off-reserve or urban Aboriginals is mired in confusion, the roots of which lie in the Constitution.

In his landmark 2003 report, *Learning from SARS: Renewal of Public Health in Canada*, which paved the way for the creation of the Public Health Agency of Canada, Naylor acknowledges, as well, that the public health needs of Aboriginal people pose a set of complex questions that merit careful study, even though he acknowledges they are beyond the scope of the report. In particular, the report notes that addressing the health disparities experienced by Aboriginal people, “requires a wide-angle approach to health determinants and community development that must clearly be integrally supported and guided by the affected Aboriginal communities. A continuing challenge in mounting appropriate responses is a recurring tension between the right and aspirations of Aboriginal peoples to greater self-determination within the Canadian federation, and the uncertain effectiveness and efficiency of reinforcing the extant pattern of separate health systems for First Nations and Inuit communities. Early in its deliberations, the Committee made a strategic decision not to move into this difficult terrain, believing that a superficial verdict would do more harm than good” (National Advisory Committee on SARS and Public Health 2003, 79).

For the sake of Aboriginal people crushing under the weight of deplorable living conditions, TB should stand as a potent reminder that we put an end to the “jurisdictional shell game” that plagues the field of Aboriginal health policy (Abele and Prince 2003). A good place to start would be to open up the question of the on-reserve/off-reserve split, which, in the case of public health emergencies that do not respect physical or jurisdictional boundaries, seems unnecessarily out of date. And while there are important, albeit complex and multi-faceted jurisdictional ambiguities to iron out, there are other basic public health issues that need our immediate attention, such as clean, running water and adequate housing. Jordan’s principle, which was discussed at the outset of this paper, might be a good starting point: deal with the problem first and sort out the jurisdictional issues later. In the long term, however, the Assembly of First Nations’ recommendation for a First Nations Public Health Act might be a viable solution.

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<sup>1</sup> 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 own which are beyond the scope of this paper. For an overview of some of these issues as they affect the city of Toronto, see a Report of the Immigration and Refugee Working Group of the Tuberculosis (TB) Subcommittee of the Board of Health, “Recommendations to Improve Tuberculosis Prevention and Control in Immigration and Refugee Residents”, May 29, 2003.

<sup>2</sup> As Lavoie et al note in their exhaustive evaluation of the Health Transfer Policy, “Transfer means different things to different peoples: to some, transfer is mainly an administrative mechanism to shift financial resources for a selected number of health programs from FNIHB to First Nation and Inuit organisations. Roles and responsibilities are tied to these financial resources. To others, transfer is an opportunity for First Nations and Inuit to exercise a higher level of governance over community health care systems. Debates continue as to whether “transfer” is a policy, a program or a financial mechanism for selected programs” (Lavoie et al. 2005b: 8)

<sup>3</sup> One of the main organizations representing off-reserve populations, the Ottawa-based Congress of Aboriginal Peoples, occupies a contested place in Aboriginal advocacy, having been criticized for supporting the dismantling of Indian and Northern Affairs and the elimination of the Indian Act.