Health Research, Entitlements and Health Services for First Nations and Métis Women in Manitoba and Saskatchewan

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ABSTRACT
Since 1982, the term “Aboriginal” has been defined in the Canadian constitution as including Indian, Inuit and Métis peoples and has become part of the Canadian vocabulary. However, among the groups included in this term, there are significant differences in access to health care services based on treaty and historical entitlements and related government jurisdictions and policies. In spite of good intentions, research on Aboriginal women’s health can fall short when it fails to recognize differences in entitlements and health services available under the term “Aboriginal.” We explored the historical developments leading to current legal entitlements to health care services for First Nations and Métis women. We then interviewed service providers in Manitoba and Saskatchewan to investigate women’s access to health, including barriers created by differing entitlements to services and lack of understanding about services. We discuss why the differences in health service entitlements must be taken into account for health research.

KEYWORDS
Aboriginal women, women, First Nations, Métis, non-Status, access to care, entitlements, health jurisdictions, research methods, health research
“It almost seems like the general population doesn’t understand that there’s specific benefits for each of us and if you are First Nations you can access [certain programs and services] as long as you have that 10 digit number but First Nations women without Treaty Status, Métis women, and other women are distinctly different and if they do not have that 10 digit number they do have access to the same kinds of services and programs.”

– Service Provider

INTRODUCTION

Since 1982, the term “Aboriginal” has been defined in the Canadian Constitution as the descendants of Canada’s original inhabitants, specifically Indian, Inuit and Métis peoples (Canada, 1982). The word “Aboriginal” is now part of the Canadian vocabulary. However convenient the term may be, Aboriginal groups have unique cultures with different languages and traditions and should not be thought of as homogeneous. There are particular implications in the realm of health care because terminology, identity, and legal status have direct bearing on who receives what health benefits. To ensure that differences in entitlements and access to services are taken into account, new health research must include a precise description of the women in entitlements and access to services are taken into account, new health research must include a precise description of the women or men involved, which requires researchers to learn about and understand the history and current entitlements.

This project was developed in response to community women’s requests; to describe the differences in entitlements and jurisdictions for health services for Aboriginal women, to begin to understand how women are affected, and to explain why these differences should be taken into account in health research. The focus is on Métis and First Nations women (including women with and without Indian Status) in Manitoba and Saskatchewan.

Who are the Women? Understanding the Labels and the History

Indian and First Nations

“Indian” was used to describe the original inhabitants of North America by European colonizers. “First Nations” is not a legally defined term but is a recent, more positive way to describe a particular band, people or residents of a reserve.

Treaties are signed agreements between First Nations and the British Crown (thus, the Government of Canada) in which the First Nations agreed to share the land and the Crown agreed to provide certain protections and rights to the First Nation(s) signing the Treaty and their descendants (Daugherty, 1983). Although it is not the case in all parts of Canada, the lands in what are now the provinces of Manitoba and Saskatchewan are covered by treaties.

These treaties are critically important to current health services because of the federal government’s commitment, in signing, to provide health care. For example Treaty 6, which was signed in 1876 by the Cree Nation in relation to land in Saskatchewan and Alberta, includes a clause stating that a “medicine chest” will be kept in the house of each Indian Agent for the benefit of the Indian people. There was considerable debate in the following years about its meaning but the “medicine chest” clause was eventually interpreted to mean government provision of free medical care to Indian people (NAHO, n.d.). There are significant differences of opinion concerning the provision of this care. First Nations view federal health programs as a right based on a fiduciary responsibility, while the federal government views their provision of health services as voluntary, due to a policy commitment only.

The British North America Act (BNA Act) established the country of Canada in 1867. Section 91(24) of the Act states that legislative authority for “Indians, and Lands Reserved for the Indians” rests with the federal government (Canada, 1867). The BNA Act granted some of the responsibility for health care to the provinces while the federal government retained responsibility for certain aspects of health for all Canadians. This division of responsibilities created a complication for First Nations: since it was the British Crown that had signed the original treaties and the “medicine chest” clause, that responsibility now rests with the Canadian federal government, but the provincial governments have responsibility for health care provision to residents.

The Indian Act (1876 and 1958) defines the term “Indian” and spells out all the rights and entitlements of Status Indians. According to the Act, “Indian” “means a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian.” Under the Indian Act, people with Status had rights to live on a reserve, vote for chief and council in bands, share in band money, and own and inherit property on a reserve. “Status” was handed down along the male line of the family (dismissing traditional matriarchies). The Act set the conditions under which an Indian person becomes enfranchised, that is,
acquires full Canadian citizenship (that is, loses their Status as an Indian). The Act is administered by Indian and Native Affairs Canada.

The term First Nations is used to describe Indian people whether or not they are registered with Status. Because of the extent of coverage of the lands by Treaty in Manitoba and Saskatchewan, and their connection to Indian Status, the terms “Treaty Status,” “Treaty Indian” or “Treaty” are frequently used to describe Indian people who have Status related to being covered by a Treaty.

Bill C-31, an Act to amend the Indian Act, was passed in 1985. The intention, in writing it, was to comply with the Canadian Charter of Rights and Freedoms (1982) and to correct the sex discrimination in the Indian Act that until then stripped a woman of her status if she married a non-Status man. According to Section 6 (1) of Bill C-31, the following groups are now entitled to Status registration:

1. People who already had Status before Bill C-31, including women who had acquired Status under the Indian Act when they married a Status man. (This can include Métis, Non-Status, Inuit or non-Aboriginal women).
2. People who had been removed from the Register because they or their mother had married a non-Status (or non-Indian) man.
3. People who had been removed from the Indian Register through “voluntary” enfranchisement.
4. People who had been removed from the Indian Register through other forms of involuntary enfranchisement (e.g. for joining a profession or receiving a university degree).
5. People whose parents were both entitled to registration under Bill C-31.
6. People who have one parent who can register under Section 6 (1) and one parent who is not entitled to register, are still entitled to register under Section 6 (2) of the Bill.

However, the children of people who register under Section 6 (2) have different rights and entitlements than do the children of people registered under Section 6 (1). This has been referred to as the second-generation cut-off (Figure 1) (Mother of Red Nations, 2005). As well, entitlements reinstated under Bill C-31 do not necessarily translate into band membership. Mother of Red Nations Women’s Council of Manitoba (2005, 2006) notes that women with Status who do not have band membership do not always receive their rights, privileges and services to which they should be entitled. Since its introduction, Bill C-31 has been challenged repeatedly because instead of reducing discrimination against women, it has created a new class of people:

The Bill has created new divisions in Aboriginal communities and deepened some old ones - between Aboriginal people who have Status and those who do not, between people living on-Reserve and off, and between people who have band membership and those who do not (Mother of Red Nations, 2005).

Métis

Métis are people of mixed Indian and European ancestry. On the prairies, the European ancestors were the first white settlers: English, Scottish, Irish, and French. Métis peoples have a distinct culture and in some areas a distinct language.

During the last several years, Métis organizations across Canada have been consulting with their members, legal experts and historians to develop a nationally accepted definition agreed to by the Métis people. In 2002, the Métis National Council (n.d.) comprised of Métis organizations from Ontario westward, defined a Métis person as “… a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation.” This definition confines the use of “Métis” to descendants of the peoples from the historical settlements in the Prairies, Ontario and British Columbia, the “Historic Métis Nations Homeland,” but could enforce the argument that the government has historical obligations to Métis people (under this definition) and their descendants. Others might endorse a broader definition of Métis people based on self-identification and recognition by the Métis community. The national Congress of Aboriginal Peoples, which does not focus on a definition of Métis, works to represent the interests of Indian people who do not have Status, and Métis people, including people from British Columbia, Manitoba and other Eastern provinces (Congress of Aboriginal People, 2007).

Métis people were not signatories to treaties. Aside from a few limited grants or programs, the Métis people do not receive additional health services from the federal government. The Royal Commission on Aboriginal People noted that “…both Métis and non-Status Indians have been considered, for jurisdiction purposes, a part of the non-Aboriginal population by the federal and provincial governments” (Commission on Aboriginal Peoples, 1996). However, all groups representing Métis people have for many years stated.
that, as one of the founding peoples of Canada, they should be receiving additional consideration in health care and other areas.

**What the History Means in Terms of Entitlements to Health Services**

The Canada Health Act passed in 1985 outlines the provisions for federal, provincial, municipal, and territorial governments in the delivery of health care services, including cash disbursements for declared services (Government of Canada, 1985). These provisions include universal access to insured hospital care and primary health care provided by doctors and other health care professionals, although there is a variation by province, health region within provinces and geographic location. Health Canada (2006) reports that all Aboriginal people have access to these services, as does any other resident of Canada. However, Inuit and First Nations people who are registered as Status are entitled to additional federal health services. Until recently, the federal government did not acknowledge any additional responsibilities for Métis people’s health other than those assumed for the general population of Canada.

As Boyer (2003) states, “Since 1982, Aboriginal and Treaty rights have been recognized and affirmed as constitutionally protected rights under section 35 of Canada’s Constitution Act, 1982.” She argues that from a legal standpoint, since non-Status Indian and Métis people are included as Aboriginal peoples, they should be entitled to all the health benefits to which their First Nations Status counterparts are entitled through the signed treaties (Boyer, 2003).

According to Boyer (2004a), despite the legal recognition and affirmation of both Aboriginal and treaty rights, the federal government of Canada still has not in good faith acknowledged what these rights mean in terms of health services to all Aboriginal peoples; from the federal point of view “the provision of health services to First Nations and Inuit Peoples is done as a matter of policy only and not because of any fiduciary obligation, or Aboriginal or Treaty right” (Boyer, 2004a). Boyer (2004b) further argues that within an international human rights context and the perspective of health as a basic human right, Canada does not meet its international and domestic obligations to provide Aboriginal people access to adequate health-related services. The implications are particularly unclear for Métis people because they have traditionally been left out of all health policy meetings until the recently held Blueprint on Aboriginal Health in which First Ministers and leaders of national Aboriginal organizations, including Métis, met to discuss the pressing health issues for all Aboriginal Peoples (Canada, 2005).

As a result, service delivery between those administered by First Nations or Métis organizations and those still managed through the federal or provincial government may differ. Service delivery between bands or Métis organizations may also differ, due to differing political priorities or service needs. As noted, a woman with Status who registered under Bill C-31, for instance, may not have many connections to a band, or her home reserve may have a shortage of resources for such things as housing, education programs or health care. Mother of Red Nations (2006) notes that while women with Status are technically eligible for additional health care,

“Access to health services becomes more difficult when someone requires specialized care or medication and resides off First Nations territory. Many specialized services require an individual to live on reserve to get the service or care, or to receive the funding for access. In addition, many of the policies related to criteria or eligibility are further defined by individual band policies and procedures and therefore can be further discriminating about who has access to specialized services” (Mother of Red Nations, 2006).

For First Nations Peoples, the issues are also complicated by discussions, tensions and wrangling between the federal government and the provinces. Allec (2005) writes, “Ample documentation attests to the fact that the long standing conflict between the provincial and federal governments has negatively impacted First Nations Peoples and has resulted in the patchwork of fragmented services which exists today…”

Saskatchewan and Manitoba provincial governments provide full coverage or partial cost coverage for a wide range of health services: medical, hospital, surgical, x-ray and other diagnostic, physiotherapy, occupational therapy, chiropractic services, optometry, home care, long-term care, mental health, public health, services for persons with disabilities, addictions treatment, health information services, some dental services, some ambulance services, and prescription drug costs. Both provinces also provide some extra coverage for low-income families or individuals (Government of Saskatchewan, 2006; Government of Manitoba, 2006).

The federal Non-Insured Health Benefits (NIHB) administered by the First Nations and Inuit Health Branch of Health Canada is the key program available to
First Nations individuals with Status (and Inuit people), but it is not available to Métis people and non-Status First Nation people (Health Canada, 2006). NIHB provides additional coverage for:
2. Mental health counseling.
3. Certain medical supplies and equipment.
4. Drugs.
5. Dental care.
7. Medical transportation.

Even for people entitled to NIHB, the complexity of the program is a problem. The lists of services, health care, equipment and drugs change frequently as there are advances in medicine, new research, or even budget changes. The Assembly of First Nations (2005) has produced an in-depth report and a strategy for addressing concerns with NIHB to ensure First Nations people have access to health care services according to need, treaty and inherent rights to health.

Despite the wide range of funded services available, the costs for services not covered or not fully covered can pose significant difficulties for women. There is an assumption that employee benefits for private health insurance coverage are widely available and that “most” citizens have such benefits. Women report, however, that part time and low-paying jobs keep them from buying drugs or health care that they need (Savarese, 2003; Deiter & Otway, 2001).

**QUALITATIVE INTERVIEWS**

To understand more about how jurisdictional differences and entitlements affect Métis and First Nations women (with and without Treaty Status) in Manitoba and Saskatchewan, we interviewed service providers, to share their understanding of the rules and regulations, and how they affect the women who are their clients.

Ten Métis and First Nations female health care workers were recruited in a non-random, snowball technique, either by telephone or email. Participating women were asked to provide their signed informed consent. The interviews were tape recorded and lasted between 45 and 90 minutes. The participants were asked nine semi-structured questions related to their experiences helping women looking for health care and their understanding of the women's rights to services. The results were analyzed for relevant themes in relation to current services and traditional knowledge. If needed, a debriefing period followed each interview to ensure recalling problematic events did not overly distress the participants.

The interviews used indigenous methodologies wherever possible. Reliance on the spoken response is in keeping with oral traditions, for instance, which is why we include direct quotes from the women who took part in this study. As well, the main researcher for this part of the project situated herself within the study as is common when using and integrating an indigenous methodological narrative approach in research (Smith, 1999). The study follows both standard and Aboriginal ethical procedural guidelines and received ethics approval from Prairie Women's Health Centre of Excellence.

All the women interviewed were involved either directly as front line workers or indirectly as managers helping First Nations, Métis or other Aboriginal women access health services and programs. All the women interviewed stated that they either experienced themselves or witnessed problems related to getting health services and programs as a result of entitlement and jurisdictional issues. They all knew women who had difficulty accessing health programs and services, no matter if they lived on-reserve, rural off-reserve, off-reserve but near-reserve, or in urban areas.

**RESULTS**

The interviews revealed three important points:

1. There are several significant barriers to health care affecting all Aboriginal women: transportation, language, age, health, lack of empowerment, lack of education, and a history of abuse and discrimination.
2. For First Nations women with Status, a lack of awareness of what their entitlements are, and what programs and services are available to them as part of their entitlements, keeps women from getting the care and service they need.
3. For Métis and non-Status women, the most significant point is the women's complete lack of entitlements beyond what is provided by the provinces.

Providers spoke of the confusion among women about the services and programs to which they are entitled, lack of general information, and the need to dispense with the artificial lines of jurisdiction for families and neighbours.

Recent cutbacks to the benefits covered by the NIHB program have restricted access to proper medical treatment for some women; final approval comes from NIHB.

Sometimes there is confusion concerning the paperwork...
required for approval to receive benefits. For example, as one woman stated,

A couple of years ago there was a medication that was quite costly, and the client could not afford it, and they wanted the client to write a letter, but they denied it. It was a prescription for dementia. They wanted the client to write a letter explaining why it was needed. We wrote the letter back, asking how a client with dementia could be expected to write a letter.

It would seem that this type of written confirmation should have been prepared by a doctor. Another woman explained,

We had a client denied a walker, she got a prescription, had taken it to wherever, and it was not covered. So [she] came, and we wrote the letter, and they wrote the letter back stating that [she was] not covered unless [she was] oxygen dependent, overly obese, so we purchased a wheeled walker, and lent it to [her].

Bill C-31, as noted, provides for the reinstatement of persons who lost their Status through the Indian Act. There are many cases of women who have different Status from their children, or in some cases, from their husbands. The women reported that when complaints are voiced to federal officials they are told that the band gets money for Bill C-31 individuals and so complaints should be addressed to band leaders. When the complaints are taken to the band officials, the officials deny that funds are received in this manner.

On the other hand, non-Status and Métis women have no entitlements. Many people do not have private or employment-related health insurance to cover the extra costs of dental and eye care, extra prescriptions not covered in the drug formularies or ambulance transport. “If you are Métis and you don’t have money how are you going to access medicine?” one provider asked.

Some providers work around these limitations, providing care and help to anyone who lives on a reserve. One woman stated,

It doesn’t matter if they are Métis, Status or non-Status. For Non-Status peoples we do our best here at the clinic to get their equipment or whatever they need provided that they stay on the reserve. But once they leave the reserve ... I guess that is when the province or whoever takes over.

The same woman commented on how it is more difficult to give non-Status people access to needed drugs.

We are not able to access drugs for them. Basically if they are non-Status they are on their own. We had a little fund here at the clinic where people who cannot purchase the drugs on their own, we help them out [with] that.

Provincial welfare systems can make these issues more complex. One provider gave the following example,

I had a person come up to me who lives in the community, but I think that she’s Métis, and I don’t know if it would make a difference or not that she’s on provincial welfare, because if you’re on provincial welfare, and live in the community, that is who gives you your welfare whether you’re Treaty or not. I understand that the mother had a child that was medi-vaeced to [place], so the Mom obviously went with the child because the child was under age. Three days into whatever was wrong with this child, the Mom was still in [place], and I don’t know how this system works, but income security got a hold of her, and they were going to start deducting from her welfare check because she was in [place], and they were going to pay [where she was staying], and reduce the amount of her monthly check because she was in [place].

There is a sense that the real needs of the women are not taken into account.

One woman stated:

We try to phone people to state our concerns but we get the blind eye you could say from government people because basically the decision making is done through there...[but] it affects the grassroots people. Not really thinking that it is expensive to live up North, not to mention your medical expenses, when you are being flown out of Winnipeg. Or you could be flown to Thompson and then Winnipeg.... You don’t have to pay for the air transportation to get you to the nearest care facility, but you have to pay for all those [other] ambulances. It’s a burden.

Another service provider said,
I think that maybe sometimes there may be some covert exclusion, stemming from a lack of understanding about some of the issues or ability to empower Aboriginal people as well as other cultures.

The on-reserve and near-reserve health care providers, however, had no problems defining and discussing the difficulties associated with access to programs and services. They spoke of difficulties in transportation, language, inadequate or insufficient numbers and kinds of programs offered, lack of awareness of what programs and services are available, lack of awareness of what funding resources are available (i.e., what will be covered by their First Nation or other funding sources), discrimination towards addicts and women of the street, and tedious FNIHB and provincial policies related to access to medications, services and programs.

Given the geography of Saskatchewan and Manitoba, community isolation and the vast distances that must be traveled, transportation for medical purposes is a prime issue for all Aboriginal women. Participants spoke of how the mode of transport is determined by Status. A Métis woman commented,

We all go to the same health centre but another example would be if I had an appointment in Winnipeg, made by the doctors here. If I had to go I would get a warrant from the nursing station and I would go on the bus. If my daughter, who is Status, went to the nursing station with me, she would fly to Winnipeg, so that’s a big thing we see. My brother had an angioplasty done and the next day they wanted to send him home on the bus, and he couldn’t even walk. That’s through Northern Transportation, so that is government policy. It’s mainly because he wasn’t Treaty at the time, but now he’s Treaty, so now he gets to fly. In Winnipeg, if you had to go to Toronto if you were Status you would fly, but if you’re not you’d have to take the bus.

As one interviewee stated on the topic of access, “...if a Métis person is medi-vacced out of the community and if you’re not on welfare you are basically on your own.”

DISCUSSION AND CONCLUSIONS

There is no shortage of documentation about the poor health status of Aboriginal people in Canada, including women (Dion Stout et al., 2001). However, despite the many materials written and the promises of programs and funds, the situation persists. Some recent attention has been given by policy makers and politicians to improve access to care, and by implication reduce the inequities.

Understanding the current situation takes some time, since entitlements to health care services are complicated by over 400 years of colonial rule and more than 150 years of legislation and policy. We have seen that there have historically been differences in entitlements to health care services for Métis and First Nations people.

Women are affected differently than men because provisions under the Indian Act made Indian women more likely than men to be enfranchised through marriage. Indian Status reinstated under Bill C-31 provides some women with renewed entitlements, but not all women have been treated equitably. Métis residents, as noted, are entitled to only those health care services available to all provincial residents. Settlement patterns, family ties and geography have contributed to having some people receiving health care on one side of a road (or lake) and others not.

The term Aboriginal is an accepted term and is in our Canadian Constitution, but it clearly has limited value when discussing health care services and access to care. For policy makers and providers directly involved in health and Aboriginal issues negotiations and discussions, the differences in health entitlements among Aboriginal people are central. But in many documents and discussions about Aboriginal health, the ambiguity about who is being discussed remains, or the population included varies substantially. To ensure that differences in entitlements and access to services are taken into account, new health research must include a precise description of the Aboriginal women involved, which requires researchers to learn and understand the history and current entitlements.

Health Research that Includes Health Entitlements

While the poor health status of First Nations women has been documented, there is less data available for Métis women. As well, there has been only limited research done on the factors that influence women’s health or positive health practices (see Bennett, 2005 for example).

Recently, Aboriginal organizations are taking a lead in guiding new research that is culturally appropriate. New
protocols and ethics standards have been developed for doing research appropriately with, for and by Aboriginal women (Saskatoon Aboriginal Women's Committee, 2004; Canadian Institutes for Health Research, 2005).

Any research or new study examining determinants of health, healthy living, health care access, outcomes, wait times, or service provision must be very clear about the population to be studied or involved in the study and what legislated entitlements they have. Researchers must bear in mind that even members of the same family may be technically entitled to different health care. As well, in many communities in Manitoba and Saskatchewan (Cross Lake and The Pas, for example) where reserve and non-reserve lands are adjacent, the residents live their lives on one side and the other, but cannot necessarily seek or receive the same health care services. Researchers must also become familiar with the study community's history and how women of the community can or cannot make use of the project, program or service examined. A research study of health care access requires this historical and entitlement account to set the context fully.

Research based on existing administrative, survey, population, and other data sets is limited by how populations were included. For example, Statistics Canada uses several methods for identifying Aboriginal ancestry; most often using a broad definition, allowing survey and census respondents to self-identify as having Aboriginal ancestry. Some First Nations reserves, however, refused to take part in some national surveys, and in other cases survey design did not include residents of the northern territories, most of whom are Aboriginal. Manitoba Health, in contrast, collects health utilization data about all Manitobans and data can be retrieved about those persons who voluntarily declare their First Nations status to Manitoba Health. The Manitoba Vital Statistics registry of deaths, however, includes as “First Nations” all those, and only those, whose place of residence at the time of their death was a First Nations reserve, thus excluding all Aboriginal Manitobans who live off reserve and making no distinction about Métis or Status (Donner et al., 2006). Smylie and Anderson (2006) summarize the numerous limitations in the existing data sets. The authors also note that the population health measures were by and large set by non-Aboriginal people and do not yet include health measures that reflect Aboriginal health concepts. The authors state “…data coverage and quality, data jurisdiction and utility, data governance and relevance, and infrastructure and human resource capacity” are challenges to any measure of Aboriginal health in the existing health measurement systems. That is, using or interpreting these data without the context of health entitlements can lead to erroneous understandings of the health of a population.

Lost in the confusion of words and regulations are the women themselves. As we have seen, Aboriginal women and the people who wish to assist are equally entangled in the words and regulations. Although they are directly affected, the women may not have the time to sort it out or adequately gain thorough explanations of the complex details of evolving policies and regulations. But women do recognize the inconsistencies in the treatment of First Nations with Status, those who do not have Status, and Métis people. Further research on the specific differences and how access to services particularly affects women’s health would provide greater insight into priorities for addressing the problems created by jurisdictional differences – but it would not diminish the urgency of the current recommendations from the women in this study for improving health and access to health care.

The providers interviewed for this report see access to services as linked with a number of factors affecting their lives and the lives of the women they work with, and state that these factors must be taken into consideration and addressed. They also emphasize that work must be done to ensure a more sensible and equitable way to provide health services to all Aboriginal people.

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