

ACROSS THE ROAD: UNDERSTANDING THE DIFFERENCES IN HEALTH SERVICES AVAILABLE TO FIRST NATIONS AND METIS WOMEN

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There are legal differences in the health services First Nation, Métis and Inuit women receive – not all Aboriginal people in Canada receive the same health services. This fact is often not fully recognized or well understood.

“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 as long as you have that 10 digit number but First Nation women without Treaty Status, Métis women, and other women are distinctly different and if they do not have that 10 digit number they do not have access to the same kinds of services and programs.” – Service Provider

This document explains the history of the differences in legal entitlements to health services for First Nations and Métis women¹. It is a summary of the report *Entitlements and Health Services for First Nations and Métis Women in Manitoba and Saskatchewan*².

The original paper was written for both health researchers and policy-makers to examine the legal entitlements for health care services, clarify the terminology, and most importantly to demonstrate how they affect the women seeking health services. The report reviewed the legislative history of entitlements to health services in Canada, outlined current developments and provided information about the health services available. It included the results of a qualitative research project on the experience of front-line providers who work with Métis and First Nations women in Manitoba and Saskatchewan. Finally, suggestions were provided for both policy-makers and researchers regarding how this information applies to research and to policy, planning and service delivery.

The Women

Differences between women and men in health status and use of health services are related not only to biological differences, but also to women's and men's social roles. Whether in Aboriginal or non-Aboriginal cultures, women play a primary role in maintaining the health of their families. Aboriginal women also play an increasingly greater role as paid health professionals.

In both Saskatchewan and Manitoba Aboriginal people are a significant portion of the population. It is difficult to determine exactly how many women would be directly affected by the issues raised in this paper, but statistics do provide us with some general estimates. According to the 2001 Census of Canada, thirteen percent of the Saskatchewan and Manitoba populations reported having an Aboriginal identity. In Saskatchewan this grouping represented 66,895 girls and women. In Manitoba 77,010 girls and women identified as having an Aboriginal identity. (See “How Many Women?” section for a more details about these figures.) These statistics do not describe the number of women are affected by differences in entitlements for themselves, their families and their communities.

The Term “Aboriginal”

“Aboriginal” is a term employed in political and policy discussions over the last thirty years to identify descendants of Canada's original inhabitants. The term has a specific use in the Canadian Constitution of 1982, where Aboriginal people are defined as including “Indian, Métis and Inuit people”.³

Why Are There Differences?

The current entitlements to health services in Canada have been created by a long history of events (see box).

Prior to European colonization, the original inhabitants of Canadian lands identified themselves in their own languages. The word “Indian” was used to describe the original people of North America by Europeans and is still used in historical and legal references. Métis people, settlements and culture arose from the joining of First Nation and European people. The people living in the far north were referred to as Eskimo, but are now more correctly called Inuit.

The federal *Indian Act* (1876 and 1958) created a legal definition and requirements for Indian people. “Status Indian” is the legal term for someone who is registered as an Indian under the *Indian Act*; and will be used in this paper. Because of the register kept by the federal government, the term “Registered Indian” is also used. Status Indian individuals are entitled to receive additional federal health services.

Indian people are registered and have Status because of treaties their ancestors signed, or because of other agreements with the Crown or the Government of Canada. Those that have Status due to treaties are sometimes referred to as having “Treaty Status”. This term is more common on the Prairies where Treaties covered all of the land. Most people with Status are of Indian ancestry, however in the past some non-Indian women gained Status when they married an Indian man with Status (and they retain this designation).

Some Indian people are legally “non-Status” because they are not registered under the *Indian Act*. This situation can have occurred either because their ancestors were never registered, or because Status was lost through marriage or other provisions of the *Indian Act*. Women would lose their Status by marrying a man not registered as a Status Indian (a non-Status Indian man or a man with other ethnic background). Indian people who are non-Status are not entitled to additional federal health services.

There are women and their children who have regained Status by applying under the provisions of federal Bill C-31. This legislation was passed in 1985 and allowed reinstatement of Indian Status to women who had lost their Status due to marriage. Those reinstated may refer to themselves as being a “Bill C-31”. The clause of Bill C-31 under which women register is also significant, and women may refer to themselves as [section] “6(1)’s”, “6(2)’s” or “half-Status”.⁴ Women registered under Bill C-31 are technically entitled to additional federal health services but may not actually receive some services because they do not have a Band membership, or are not living on a reserve. The effects of Bill C-31 reinstatement change as the generations progress, as Figure 1 illustrates.

Key Events Related to Entitlements to Health Services:

1763 – 1906: Royal Proclamation & First Nations Treaties

1870 to c1906: Métis scrip

1867: British North America Act

1876 and 1958: Indian Act

1982: Canadian Constitution & Charter of Rights and Freedoms

1982: Women’s Equality Provisions

1985: Canada Health Act

1985: Bill C-31

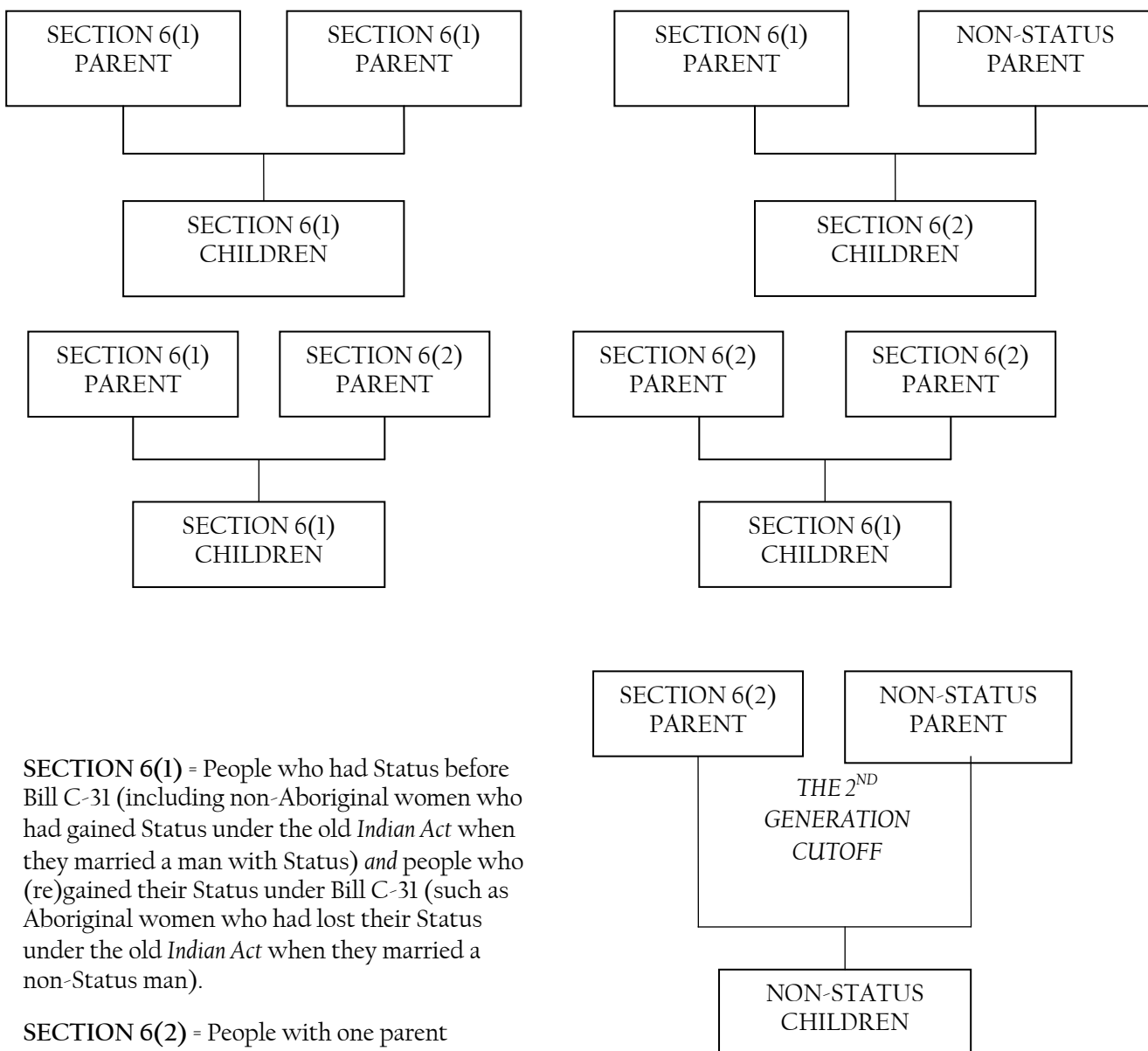
1996: Royal Commission on Aboriginal People

2002: Métis Nation Council Definition

2004 – 2005: Federal Roundtables on Health

2005: Kelowna Accord

Figure 1. Entitlement to Indian Status under Section 6 of the Bill C-31 amendments to the *Indian Act*, for children born of various parenting combinations (with permission from MORN 2005)⁵



SECTION 6(1) = People who had Status before Bill C-31 (including non-Aboriginal women who had gained Status under the old *Indian Act* when they married a man with Status) and people who (re)gained their Status under Bill C-31 (such as Aboriginal women who had lost their Status under the old *Indian Act* when they married a non-Status man).

SECTION 6(2) = People with one parent entitled to registration under Section 6(1) and one parent not entitled to registration. This includes most of the children of women who had lost their Status for “marrying out” under the old *Indian Act* (notably, it does not include the children of women who gained Status by “marrying in” under the old *Indian Act*).

Only the children of Section 6(2) parents can be denied Status, on the basis of the 2nd generation cutoff.

Coming to Terms with the Labels

- Aboriginal** – The original people of Canada and their descendants. This term is used in the *Constitution of Canada* [s.35.1 (1982)] and refers to “Indian, Métis and Inuit people”.
- Aboriginal Peoples** – Collective name for all of the original peoples of Canada and their descendants.ⁱ
- Aboriginal people** – Using people (lower case) refers to more than one Aboriginal person rather than the collective group of Aboriginal Peoples.ⁱ
- Band** – As defined by the *Indian Act*, a body of Indians for whom lands have been set aside or monies held by the Government of Canada or who have been declared by the Governor in Council to be a Band. Today many Bands prefer to be known as First Nations.ⁱⁱ
- Band member** – A recognized member of a Band, whose name appears on the approved Band List. Bands that have adopted their own membership codes may define who has a right to membership in the Band, so being a Status Indian may not be synonymous with being a Band member.ⁱⁱ
- Band Chief** – Leader of a Band and Band Council. The Chief is elected by eligible voters of the Band, or by the councillors, according to the regulations of the *Indian Act*.ⁱⁱ
- Band Council** – Governing or administrative body of a Band, elected according to procedures laid out in the *Indian Act*. Councillors are elected by eligible members and serve two or three year terms.ⁱⁱ
- Bill C-31's** – Shorthand reference to people who have regained their Indian Status due to an application under Bill C-31 (passed in 1985). Bill C-31 allowed reinstatement of women and their children who had lost their Indian Status due to marriage with a non- Status Indian or a non-Indian.
- First Nations** – Used in recent years to describe the groups of original inhabitants in what is now Canada, in preference to the word “Indian”. However “First Nations” is not a legally recognized term. It does not include Inuit or Métis people.
- Indian** – First used by Europeans to describe the original inhabitants of North America. Used in the Constitution of Canada and the *Indian Act*.
- Indigenous people** - Descendants of the original inhabitants of particular regions or territories.ⁱⁱⁱ
- Inuit** – Original inhabitants of northern Canada living generally above the tree line. Inuit are not covered in the *Indian Act* but the federal government makes laws concerning the Inuit. Inuit are included as Aboriginal people in the Canadian Constitution.
- Inuk** – An individual Inuit person.
- Métis people** – People with mixed Aboriginal and European ancestry who identify themselves as Métis, distinct from Indian people, Inuit, or non-Aboriginal people. They are included as Aboriginal people in the Canadian Constitution.
- Métis National Council Definition:** “Métis means 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.”^{iv}
- Mixed blood, Half-breed** – Terms used to refer to persons of mixed ancestry which had negative or racist overtones, but are being reclaimed by some groups or individuals, especially to include persons of mixed blood who do not fit the more formal definitions of Métis.
- Native** – Used in North America to refer to persons of any Aboriginal ancestry. In Canada, this term has acquired some negative overtones, but is still used by some individuals and groups. Commonly used in the United States in the term “Native Americans”.
- Non-Status Indian** – Person who is not registered as a Status Indian under the *Indian Act* either because the person or his/her ancestors were never registered, or because Status was lost through marriage or other provisions of the *Indian Act*, but who identifies as First Nations.
- Reserve** – Lands owned by the Crown, and held in trust for an Indian Band. The legal title to Indian reserve land is vested in the federal government.ⁱⁱ
- Status Indian** – Legal term for a person who is registered as an Indian under the *Indian Act* of Canada.
- Treaty Indian** – Person who is a Status Indian because he or she is a member of a First Nation that signed a Treaty with the British Crown. A person is sometimes said to have Treaty Status.

i. National Aboriginal Health Organization, “Authors Guidelines for Article Submission to the Journal of Aboriginal Health”

http://www.naho.ca/english/journal_Guidelines.php

ii. First Nations and Métis Relations Glossary. Saskatchewan Government First Nations and Métis Relations Department

<http://www.fnmr.gov.sk.ca/glossary.htm> [Retrieved December 1, 2006]

iii. Indian and Northern Affairs Canada, “The International Decade of the World's Indigenous People”

http://www.aincinac.gc.ca/pr/info/infol23_e.html

iv. Métis National Council. “Who are the Métis? National definition of Métis”, <http://www.metisnation.ca/who/definition.html>

The term “First Nation” is not legally defined, but it has become the preferred term to refer to Indian people. The plural “First Nations” refers to the collective of all the nations across Canada. First Nation can be used to describe origins – based on the original societies, such as saying a person is “from the Anishinabe First Nation”. Some individual bands or reserves refer to themselves as a First Nation (for example Muskowekwan First Nation). Other reserves may be more specific, such as Shoal Lake Band of the Cree Nation or Whitecap Dakota/Sioux First Nation. It is worth noting that many communities had a European name assigned for many years and are now returning to their own names, in their own languages. Confusion is created when “First Nation” is used to refer only to individuals with Status, and individuals without Status are referred to as “non-Status”, when both are really from First Nations. In this paper the term “First Nation” will be used to refer to people with and without Status, with differentiation between Status and non-Status, where appropriate. In this paper the term Indian may be used where necessary to refer to historical or legal matters.

The term “Métis” is commonly used to refer to people with mixed Indian ancestry. Métis people are included as Aboriginal people in the Canadian Constitution, but the Constitution did not define the word “Métis”. Over the years there have been many discussions and definitions of the term. The complexity of the situation created by the history and legal definitions is illustrated in a table by the Congress of Aboriginal Peoples of the groups of people who are in its constituency.⁶ The Métis National Council defines Métis people as descendants of historical Métis communities.⁷ Métis people, however they are defined, do not receive any additional health services from the federal government.

The federal government does not accept that it has any additional responsibilities for Métis health other than those it holds for the general population of Canada.⁸ Rather than being part of treaties, Métis were offered “scrip” in areas where a treaty had already been signed with Indian people, or was being negotiated. Scrip was a government-issued certificate entitling the bearer to a specific amount of land or money, but not a specific piece of land. Not everyone eligible received scrip. Many Métis who got scrip were later persuaded to sell their land for money, leaving them without a land base. Scrip did generate records of the people who applied, which are now one way of identifying Métis families.

Inuit are a distinct Aboriginal people, many of whom live in the north above the tree line. They receive additional health services from the federal government. The federal government views the provision of extra health services as voluntary, while Inuit (and other Aboriginal) people view federal health programs as an Aboriginal right based on a fiduciary responsibility.⁹ Inuit people are not discussed extensively in this paper because their numbers are small in Saskatchewan and Manitoba, but the importance and interconnectedness of their health issues are recognized.

The preceding is a simplified description of a lengthy history, and further study is recommended for a fuller understanding. Yet, even from this brief outline, it is clear that there are many complications in the definitions that have been placed on the original inhabitants of Canada by the rules of government and administration. These lead to current differences in access to services.

Entitlements and Health Services

The *Canada Health Act* outlines the provisions that guide federal, provincial, municipal and territorial governments in the delivery of health care services. Primary responsibility for healthcare services rests with provincial governments. Saskatchewan and Manitoba provincial governments provide full or some cost coverage for a wide range of health services including medical, hospital, surgical, x-ray and other diagnostic services, physiotherapy, occupational therapy, chiropractic services, optometry, homecare, long term care, mental health, public health, services for persons with disabilities, addictions treatment, health information services, some dental services, prescription drug costs, and some ambulance services. Both provinces also provide some extra coverage for low-income families and individuals.^{10, 11, 12} All Aboriginal people are eligible to these services, like any provincial resident.

First Nations people with Status and eligible Inuit people do receive additional federal health coverage. This includes health programs provided on reserve or at a First Nation or Inuit community location, and the Non Insured Health Benefits Program (NIHB). A person is eligible for NIHB if she or he is a resident of Canada and is: a registered Indian according to the Indian Act; an Inuk recognized by one of the Inuit Land Claim organizations; or an infant less than one year of age, whose parent is an eligible recipient.¹³

As the federal department responsible for health describes,

“There are a number of health-related goods and services, however, that are not insured by provinces and territories or other private insurance plans. To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada’s Non-Insured Health Benefits (NIHB) Program provides coverage for a limited range of these goods and services when they are not insured elsewhere.”¹⁴

The NIHB covers:

- short-term crisis intervention,
- mental health counselling,
- certain medical supplies and equipment,
- drugs,
- dental care,
- vision care, and
- medical transportation.¹⁵

The benefits are considered for coverage, if and when:

- the item or service is on a NIHB Program benefit list or schedule;
- it is intended for use in a home or other ambulatory care settings;
- prior approval or predetermination is obtained (if required);
- it is not available through any other federal, provincial, territorial, or private health or social program;
- the item is prescribed by a physician, dental care provider, or other health professional licensed to prescribe; and
- the item is provided by a recognized provider.¹⁶

Patients must submit claims to private health care plan, or public health or social program first before submitting them to the Non-Insured Health Benefits Program.¹⁷ For the most part, the NIHB program is billed directly by the health care service providers. If recipients do pay directly for their goods or services, they can apply for reimbursement. Requests for reimbursement must be received on a NIHB Recipient Reimbursement Request Form within one year from the date of service or date of purchase. There is an appeal process for recipients denied a benefit, but it is often considered tedious and lengthy, which can lead to recipients going without a service rather than going through the appeal process.

Provinces also administer social welfare systems. First Nation people with Status living on a reserve in Manitoba or Saskatchewan can receive social assistance from the Department of Indian and Northern Affairs under the same terms and conditions as offered by the provincial governments. If First Nations people establish residence off-reserve, they are subject to the same eligibility criteria as other residents for provincial social assistance. Manitoba and Saskatchewan do provide dental care, eyeglasses and other services for people receiving social assistance. In Saskatchewan the social services department nominates clients to the health department for supplementary health benefits. However, a client already covered by NIHB would not be eligible for provincial supplementary health benefits.

Despite the wide range of funded services, the costs for services *not covered* can pose significant difficulties for women. There is a presumption 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.¹⁸ Because Métis people and First Nations people without Status were not covered by provisions under Treaties or other obligations, they have not been eligible for the additional coverage.

Key Issues

While women may be entitled to services, either under the provincial health program or federal programs, women living in rural and northern areas or on-reserve must often travel long distances to obtain certain services. Services may not be culturally appropriate – they may not take into consideration the particular Aboriginal and local culture or recognize the different way of life in rural, remote or northern locations.

Métis women and First Nations women without Status are not eligible for additional federal services such as the non-Insured Health Benefits Program. They must pay for extra health services such as eye care or dental services, unless they are receiving social assistance or have some of the costs covered by a health benefits program through their workplace. This imposes a greater hardship on Métis and non-Status women who experience, as a group, higher rates of unemployment, under-employment and poverty compared with the non-Aboriginal population.

For First Nations people with Status, there are some costs that are not covered by either the provincial health program or NIHB. For people entitled to NIHB, the approval processes and complexity of the program is also a problem. The lists of services, health care, equipment and drugs change frequently as there are advances in medicine or new research. And finally, as the budget available changes, certain drugs, equipment or procedures may be added or removed from the lists.

Difficulties can arise when living off-reserve and trying to obtain specialized services:

“For the most part, health care provisions such as eye glasses and prescription medication are covered by Non-Insured Health Benefits equally for those who live on and off reserve.... 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.”¹⁹

A study of Aboriginal people with disabilities in Regina and Saskatoon also found that jurisdictional issues affected service access. A move to the city to access health and social services as a result of a disability or deteriorating condition often lasted months or years. This life off the reserve was often lonely and isolating as the First Nation people were enveloped in an urban culture from which they were socially excluded.

“The primary reason for moving into the city was to access services. Interestingly, the federal government directs its health funding through the [then] Medical Services Branch of Health Canada or Indian Affairs. Therefore, in order to access funds for support programs, physical aids and services, First Nations individuals must apply to their Bands for approval for payment, then apply or go to the provincial departments or non-profit organizations for the service or aid. Since they are no longer located on the reserve, these individuals with disabilities get the “ping pong” treatment, shuffled from one agency to another. Provincial government programs are reluctant to become involved and refer these patients to the federal agency: Medical Services refer to the Band government. The Band administrators hold an “out of sight, out of mind” attitude and refer to provincial programs. The situation is extremely frustrating for both clients/consumers of service and professional service providers. The research participants repeatedly and emphatically complained about accessing services and in frustration, they simply “gave up asking”. Many reported managing “on my own” without supports and services to which they were fully entitled.”²⁰

The problems in addressing health issues are a concern for health professionals. The lack of clear jurisdiction on health issues creates a lack of accountability as well as gaps and grey zones in funding and delivery of services, thus interfering with attempts to improve equity in health status and access to health services.²¹

For women who carry much of the responsibility for health care in families, there is the difficulty of trying to arrange health care for neighbours or family members who happen to have different Status under the *Indian Act*. This is a source of confusion and tension.

As more control over health is moved to First Nations, Métis and Inuit communities, the Native Women's Association of Canada (NWAC) recommends that health models for increased control over the administration, funding and delivery of services include participation of independent women's groups to ensure attention is paid to the particular health needs and rights of Aboriginal women. NWAC states that policies and protocols based on non-discrimination on the basis of gender should be established, along with adequate representation of Aboriginal women at all levels from service delivery to management.²²

The interviews with service providers discussed in the following section illustrate how the jurisdictional lines are blurred and difficult to navigate, and subsequently affect Aboriginal women and their communities.

Barriers to Services for Women

Qualitative interviews were conducted in Manitoba and Saskatchewan with Métis and First Nations women who are front line workers or managers helping First Nations, Métis or other Aboriginal women access health services and programs. Their positions allowed them to observe and comment on how the rules and regulations affect women seeking care. They were asked questions about their experiences in helping Aboriginal women seeking health services and their understanding of the women's rights to health care.

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 obtaining health programs and services in their areas, no matter if they lived on-reserve, rural off-reserve, off- but near a reserve, or in urban areas. The interviews revealed three significant points:

1. There are a number of significant barriers to health care affecting all Aboriginal women, including issues related to 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 the entitlements, keeps women from getting the care they need.
3. Métis and non-Status women lack any additional entitlements beyond what is provided by the provinces, resulting in inadequate coverage of health needs and a sense of lack of rights compared to those with Status.

The providers spoke of difficulties concerning the complexity of federal and provincial policies on eligibility to medications, services and programs; women's lack of awareness of what programs and services are available; women's uncertainty about what will be covered by their First Nation or other funding sources; and discrimination. Although they are directly affected, the women may not have the time or thorough explanations to fully comprehend the complex details of evolving policies and regulations. But women recognize the inconsistency between the treatment of First Nation people with Status, those who do not have Status, and Métis people.

The health care providers interviewed for this study and the women they work with see access to services is linked with a number of factors affecting their lives, and state that these factors need to be taken into consideration and addressed. They also emphasize that change is needed to ensure a more sensible and equitable way to provide health services to all Aboriginal people, whether First Nations, Métis, or Inuit.

The study used Aboriginal methodologies wherever possible. For example, a reliance on the spoken response is in keeping with oral traditions. As well, the researcher conducting the interviews situated herself within the study as is common when using and integrating an Indigenous methodological narrative approach in research.¹ The study followed both standard and Aboriginal ethical procedural guidelines and received ethical approval from PWHCE.

How Many Women?

Under the *Indian Act*, The federal government maintains a register of persons with Status (Registered Indians) and of Inuit people eligible for federal programs. Persons registering for provincial health benefits are asked to give their Indian Status Registry number. This allows the federal and provincial governments to produce statistics on health care utilization and vital statistics. However, these databases do not identify non-Status or Métis people.

The most recent population data available that identify all groups of Aboriginal people is from the 2001 Census.²³ Note, however, that complications in defining identity emerge in the Census data.

To start with, people are counted as Aboriginal in the Census if they identify as having a “North American Indian”, Inuit or Métis ancestry, if they report being a Treaty Status or Registered Indian, or if they report membership in a Band. Then there is a question of who gets counted and asked which questions. The Census of Canada provides a short form to be filled out by 4 out of 5 households and a long form for 1 out of 5 households. Questions related to Aboriginal identity are only on the long form, therefore are based on a 20% sample of the population. Incarcerated persons, homeless people and those in long-term care are not asked about Aboriginal ancestry. As well, the Census does not include reserves that did not participate (one from each of Manitoba and Saskatchewan).

Saskatchewan: According to the 2001 Census, there were 978, 933 people residing in Saskatchewan. The Census question on Aboriginal identity was answered by 963,155 people.²⁴ For those who responded, an Aboriginal identity was reported by 130,190 people or 13.5% of respondents. This included 63, 290 males and 66,895 females. Of the 66,895 Aboriginal girls and women, 43,165 reported having a North American Indian identity; 22,260 reported a Métis identity; 105 reported an Inuit identity; 425 reported a multiple Aboriginal identity; and 940 reported other Aboriginal identity.²⁵ Registered Indian Status was reported by 43,500 girls and women. In Saskatchewan, in 2001, 52% of the people with a North American Indian identity lived on a reserve, 9 % lived in a rural non-reserve area, and 39% lived in an urban location. Of Métis people, 6 % lived on a reserve, 33 % in a rural non-reserve area and 61% in an urban location. Inuit people mostly lived in urban locations.²⁶ In 2001, 50% of the Saskatchewan girls and women with North American Identity lived on-reserve, while 54% of boys and men lived on-reserve. This was similar to patterns found in a study of 1996 data for Saskatchewan Aboriginal women.²⁷

Manitoba: The total population in Manitoba in 2001 was 1,119, 583. Of the 1,103,695 Manitobans answering the Aboriginal identity question, 150,040 reported having an Aboriginal identity – 13.6% of respondents: 73,030 males and 77, 010 females. Of the Aboriginal girls and women, 46,925 reported having a North American Indian identity; 28,610 reported a Métis identity; 175 reported an Inuit identity; 250 reported a multiple Aboriginal identity; and 1,040 reported other Aboriginal identity. Registered Indian Status was reported by 47,170 girls and women.²⁸

“Of the approximately 90,000 Status Indians counted during the 2001 Census, 56% lived on-reserve, 24% in Winnipeg and 20% elsewhere – mostly in urban settings. Of the approximately 52,000 Métis, 50% lived in Winnipeg, and 50% in other urban centres and smaller communities – many in predominantly Métis communities, some adjacent to First Nations and some not.”

“Fully 48,995 or 85.3% of northern Aboriginal people are Status Indians, of whom 40,090 or 82% live on-reserve. Manitoba has a higher proportion of its on-reserve citizens living in isolated, fly-in communities than any other province except Quebec — 32% according to Indian and Northern Affairs Canada data.”²⁹

So we can see that the issues discussed in this paper affect a large number of women throughout Saskatchewan and Manitoba, and one must be clear about definitions when examining population data.

Health Research that Recognizes Health Entitlements

The general poor health of Aboriginal people in Canada is well-known, but research is limited on certain health matters or the factors that influence the health of Aboriginal women (see Bennett, for example).³⁰ And while the poor health status of First Nation women has had some documentation, there is less information available about Métis women. On the positive side, some studies have been done on the health practices women are using to maintain their health and their communities.³¹ Aboriginal organizations are now guiding research that is culturally appropriate. Protocols and ethics standards have been developed for doing research with, for and by Aboriginal women.³²

Research based on existing administrative, survey, population and other data sets is limited by how populations were included. Statistics Canada uses several methods to identify Aboriginal ancestry, most often using a broad definition, allowing survey and census respondents to self-identify as having Aboriginal ancestry. However some First Nation reserves refused to take part in some national surveys (e.g. the Census). In other cases survey design does not include residents of the northern territories, most of whom are Aboriginal (e.g. Canadian Community Health Surveys). Manitoba and Saskatchewan health departments collect health utilization data about all residents and data can be retrieved about those persons who voluntarily declare their First Nations status to Manitoba Health.³³ 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. This excludes all Aboriginal Manitobans who live off-reserve, and making no distinction about Métis or Status.³⁴

Smylie and Anderson summarize the numerous limitations in the existing data sets.³⁵ 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”³⁶ 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 information* about the health of a population.

All health researchers must be very clear about whom, and with whom, they are conducting their studies, as it will affect results and subsequent recommendations. Any research or new study examining determinants of health, healthy living, health care access, wait times, or service provision must specify the population to be studied or involved in the study and their entitlements to health care services. Researchers must bear in mind that even members of the same family may be technically entitled to different health care. Researchers must become familiar with the study community’s history and then learn 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. There are numerous communities in Manitoba and Saskatchewan (Cross Lake and The Pas, for example) where reserve and non-reserve lands are adjacent to each other and the residents daily move from one side to the other, but cannot necessarily seek or receive the same health care services.

Health Policy that Recognizes Health Entitlements

The terminology discussed in this document also needs to be understood by all policy-makers in health and other sectors. While the term “Aboriginal” is an inclusive term, enshrined in the Canadian Constitution, it is essential that policy work differentiate among people with regard to their entitlements. Those writing, or indeed, interpreting policy relating to health care services must be specific about who is being served.

Information gathering for policy purposes should include news items, reports, and consultations that draw in and should recognize the views of people with differing health care entitlements, taking gender differences into account.

When involving people in decision-making processes it is critical to have men and women representing the groups with differing entitlements and access to services. This includes considering Status and geographic location. Communication about consultations and policy also needs to consider the protocols and approaches that will work successfully with various groups of Aboriginal men and women and in different communities.

Conclusions

Entitlements to health care services are complicated by over 400 years of colonization and more than 150 years of legislation. In Manitoba and Saskatchewan the early land treaties set principles of federal fiduciary oversight for many services, including the responsibilities for providing health care. A distinction was made between First Nations individuals with Status and those without Status. Métis peoples were not included in the treaties and not all even received scrip. The segregation was perpetuated in ensuing legislation. The segregation was perpetuated in ensuing legislation, including the *Indian Act*, its revisions and the more recent amendment, *Bill-C31*. Complicated as the NIHB system is for First Nations, the system is non-existent for Métis residents, because they 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 the road (or lake) and others not.

As we have seen, the term “Aboriginal” serves as an over-arching term for the original people of Canada. But more specific concepts are needed when discussing health care services and access to care. Every new report or manuscript should include a precise description of the Aboriginal women or men involved, to continue work toward reducing health inequities.

End Notes:

¹ Legal entitlements to health services for Inuit women are also described briefly, but the focus of this document is to understand the legalities for First Nations and Métis women.

² Kathy Bent, Joanne Havelock, Margaret Haworth-Brockman *Entitlements and Health Services for First Nations and Métis Women in Manitoba and Saskatchewan*, Project #150, Prairie Women’s Health Centre of Excellence, Winnipeg, August 2007

³ Canada, *Canadian Constitution Acts 1867-1982, Constitution of Canada* [s.35.1 (1982)], Department of Justice, Canada.

<http://laws.justice.gc.ca/en/const/> and http://www.solon.org/Constitutions/Canada/English/ca_1982.html [Retrieved August 2005]

⁴ For a full investigation of how Bill C-31 affects Manitoba women’s lives, see Mother of Red Nations Women’s Council. (2005) *Bill C-31 Research Project* Winnipeg, Manitoba, and Mother of Red Nations Women’s Council (2006). *Twenty years and ticking: Aboriginal women, human rights and Bill C-31*. Winnipeg, Manitoba.

⁵ Mother of Red Nations Women’s Council. (2005) *Bill C-31 Research Project*

⁶ See the table at: Congress of Aboriginal Peoples, “CAP Constituency Table”, <http://www.abopeoples.org/about/table.html> [Retrieved May 15, 2006]

⁷ Métis National Council, “Who are the Métis? National definition of Métis”, <http://www.metisnation.ca/who/definition.html>

⁸ Boyer, Yvonne, *No. 2 First Nations, Métis and Inuit Health Care: The Crown’s Fiduciary Obligation*. Discussion Paper Series in Aboriginal Health: Legal Issues. National Aboriginal Health Organization and the Native Law Centre, University of Saskatchewan, 2003, page 5.

⁹ Inuit Tapiriit Kanatami *Backgrounder on Inuit Health For Discussion at Health Sectoral Meeting, November 4th and 5th, 2004, Ottawa, Ontario* October 20, 2004 Ottawa, Canada, page 3. <http://www.itk.ca/roundtable/pdf/20041105-sectoral-health-backgrounder-en.pdf> [Retrieved May 27, 2007]

¹⁰ Saskatchewan Health, *It’s For Your Benefit: A Guide to Health Coverage in Saskatchewan* November 2003

http://www.health.gov.sk.ca/mc_dp_skhealthbooklet.pdf “Emergency Transportation”

http://www.health.gov.sk.ca/ph_br_ae_emer_transp.html [Retrieved December 5, 2006]

¹¹ Manitoba Health, “Are You Covered?” <http://www.gov.mb.ca/health/mhsip/#insuredmedicalbenefits> [Retrieved November 2006]

¹² Manitoba Family Services and Housing, “Employment and Income Assistance Program”

<http://www.gov.mb.ca/fs/assistance/eia.html>, “infohealth Guide to health services in Manitoba” [Retrieved November 2006]

¹³ *Ibid.*

¹⁴ First Nations and Inuit Health Branch, Health Canada, “First Nations and Inuit Health: Benefits”, http://www.hcsc.gc.ca/fnih-spni/nihb-ssna/index_e.html [Retrieved September 12, 2006]

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ Ibid.

¹⁸ See for example: Savarese, Josephine, *Exploring the Intersections Between Women's Health and Poverty*, Prairie Women's Health Centre of Excellence, Winnipeg, Manitoba 2004.

¹⁹ Mother of Red Nations Women's Council of Manitoba, 2006, page 35.

²⁰ Durst, Doug and Mary Bluehardt, *Aboriginal People with Disabilities Vacuum in Public Policy*, Saskatchewan Institute for Public Policy Briefing Note, Issue 6, January 2004, Regina, pages 4-5.

²¹ Green, Michael "Aboriginal Health in Canada: In pursuit of equity", Centre for Health Services and Policy Research, Queen's University, Kingston <http://chspr.queensu.ca/downloads/epid803/2006/November%20-%20-%20Aboriginal%20Health%20and%20Equity.ppt> [Retrieved February 27, 2007]

²² Native Women's Association of Canada, *Background Document on Aboriginal Women's Health for the Health Sectoral Session, Following up to the Canada-Aboriginal Peoples Roundtable*, October 2004, page 7.

²³ More recent data regarding Aboriginal Peoples will be available in the Census 2006 Release no. 5 anticipated on Tuesday, January 15, 2008. <http://www12.statcan.ca/english/census06/release/index.cfm>, updated June 20, 2007. [Retrieved July 2007]

²⁴ Statistics Canada, *2001 Census Aboriginal Population Profiles*, Statistics Canada Catalogue no. 93F0043XIE, released June 17, 2003, last modified on November 30, 2005. <http://www12.statcan.ca/english/profil01/AP01/Index.cfm?Lang=E> [Retrieved July 2007] The population base for reporting Aboriginal identity is smaller because it is based on the 20% sample data that excludes institutional residents. Also note that these figures exclude census data for one or more incompletely enumerated Indian reserves or Indian settlements, one from Manitoba and one from Saskatchewan. See <http://www12.statcan.ca/english/Profil01/AP01/Help/Metadata/IndianReservesList.cfm?Lang=E> [Retrieved July 2007]

²⁵ This category includes those who identified themselves as Registered Indians and/or Band members without Aboriginal identity response.

²⁶ Statistics Canada, *2001 Census, Aboriginal Peoples of Canada*, Topic-based tabulations, Table 23 (Aboriginal Identity (8), Age Groups (11B), Sex (3) and Area of Residence (7) for Population, for Canada, Provinces and Territories, 2001 Census – 20% Sample), Cat. No. 97F0011XCB2001001, <http://www12.statcan.ca/english/census01/Products/standard/themes/DataProducts.cfm?S=1&T=45&ALEVEL=2&FREE=0> [Retrieved July 2007]

²⁷ Saskatchewan Women's Secretariat, *Profile Of Aboriginal Women In Saskatchewan*, Regina, Saskatchewan, November 1999, pages 13-15, <http://www.swo.gov.sk.ca/pub.html#ProfAbWomenv> [Retrieved July 2007]

²⁸ Statistics Canada, *2001 Census Aboriginal Population Profiles*, Statistics Canada Catalogue no. 93F0043XIE, released June 17, 2003, last modified on November 30, 2005. <http://www12.statcan.ca/english/profil01/AP01/Index.cfm?Lang=E> [Retrieved July 2007] See footnote 24.

²⁹ Manitoba Aboriginal Affairs Secretariat and Services Canada, *Aboriginal People in Manitoba*, Winnipeg, Manitoba, 2006, page 15. <http://www1.servicecanada.gc.ca/en/mb/aboriginals.shtml> [Retrieved July 2007]

³⁰ Bennett, Marlyn, *Annotated bibliography of Aboriginal women's health and healing research*, Aboriginal Women's Health and Healing Research Group, Vancouver, British Columbia, 2005.

³¹ Ibid. Page 44.

³² See for example, Saskatoon Aboriginal Women's Health Research Committee, *Ethical guidelines for Aboriginal women's health research*, Prairie Women's Health Centre of Excellence, Saskatoon, Saskatchewan, 2004. <http://www.pwhce.ca>

³³ The process is similar in Saskatchewan.

³⁴ Donner, L., H. Isfeld and M. Haworth-Brockman, *Manitoba field testing of gender-sensitive core set of leading health indicators*, World Health Organization and Prairie Women's Health Centre of Excellence. 2006. Available from pwhce@uwinnipeg.ca

³⁵ Smylie, J., and M. Anderson., "Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges", *Canadian Medical Association Journal* 175(6): 602-605, 2006

³⁶ Ibid.

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