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# Indian/non-Indian life expectancy

## Why the gap?

by John Richards

**B**ETWEEN THE TIME OF WRITING (OCTOBER) AND THE TIME THIS issue of Inroads reaches readers, the Romanow Commission on the Future of Health Care in Canada will have issued its final report. Whatever its recommendations, the report will generate *Sturm und Dräng* around the big health policy questions: the appropriate place, if any, for copayments imposed on patients for health services; the role of Ottawa relative to the provinces in funding and managing health programs; the virtues and deficiencies of the Canada Health Act.

Here I raise a question that will not receive much attention but should: what should be done about the major health programs Ottawa operates on behalf of Indian and Inuit Canadians? Ottawa spends about \$1.5 billion annually – well over half the federal Health Department budget – in the First Nations and Inuit Health Branch. With

qualifications, my answer is to close down the branch, and integrate Aboriginal health programs with those provided for all other Canadians by the provinces.

### A preliminary digression

In 1969, Prime Minister Pierre Trudeau and his Indian Affairs Minister, Jean Chrétien, tabled in Parliament their controversial White Paper, which proposed an end to any legal distinction between Indians and other Canadians. An honourable attempt to end



Only one third of on-reserve Aboriginals have high school diplomas. Improved education leads to more employment and hence to better health. HEALTH CANADA PHOTO

formal racial discrimination, it attempted too radical a rupture with the past. In general, communal features of culture are more important to Aboriginals than analogous cultural features are to non-Aboriginal Canadians; and for more than five centuries, those coming to this continent have recognized Indian governments separate from those of the settler population. Indian leaders denounced, and successfully blocked, implementation of the White Paper.

Over the last quarter century, what might best be described as Aboriginal nationalism has dominated the public debate – in Canada and other countries with significant indigenous populations. The result has been an insistence on that which is valuable in the Aboriginal experience, and acknowledg-

ment by the majority of historical injustices. However, Aboriginal nationalism also has negative consequences. It has rendered interracial discourse more tense. Out of fear of being accused of racism, most non-Aboriginal leaders have become mute on the complexities of how the races can live together. Filling the void have been Aboriginal leaders and judges – the courts are now an important forum for the making of Aboriginal policy.

Anthropological ideas have come to dominate contemporary discourse. Indigenous people are defined essentially by their culture, and accordingly have little in common with other Canadians. The central policy problem is not one of assuring equal individual rights and obligations among all

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Canadians, but of giving a broad interpretation to Indian treaty rights and enabling a full measure of Aboriginal self-government independent from the constraints imposed by other governments on other Canadians.

Because of all these factors, Romanow is unlikely to be blunt about Aboriginal health. Which is unfortunate. Aboriginal Canadians face more severe health problems than do most Canadians, and there is a need for blunt analysis as to why.

## Social determinants of health outcomes

Aboriginal Canadians undertook huge social and economic changes in the course of the 20th century. In early decades of the century, the overwhelming majority lived in rural hunter-gatherer societies. As recently as the 1951 census, only 7 per cent lived in cities, and among the rural 93 per cent many were still earning their living

### Aboriginals and Registered Indians

The census definition of Aboriginal has varied over the decades. The most recent data derive from the 1996 census; data from the 2001 census are not yet available. Currently, the most frequently used definition relies on the criterion of identity (Statistics Canada, *1996 Census Dictionary*, final edition, Cat. 92-351-UPE [Ottawa, 1999], p. 5):

*In 1991 and previous censuses, Aboriginal persons were determined using the ethnic origin question, based primarily on the ancestry dimension. Rather than determining Aboriginal status based on the cultural group of one's ancestors, respondents in 1996 defined themselves as Aboriginal if they personally identified with at least one Aboriginal group [North American Indian, Métis, or Inuit]. This is the first time that the [census's] Aboriginal population includes members of an Indian Band/First Nation who are not Treaty Indians or Registered Indians.*

The 1996 census still reported the number of Aboriginals determined by ethnic origin, and for some purposes this approach is more useful. In response to the ethnic-origin question, census respondents may designate only one ethnicity; Aboriginals who respond this way are single-origin Aboriginals, who are either North American Indian, Métis or Inuit. On the other hand, respondents may designate multiple ethnicities; if at least one of them is Aboriginal, the respondent is classified as multiple-origin Aboriginal. The number of Canadians having at least some Aboriginal ancestry was 1,100,000 in 1996. The number identifying as Aboriginals was considerably smaller, 800,000.

The quotation above refers to another important concept: individuals who qualify as registered Indians under the Indian Act. In 1996, the Department of Indian and Northern Affairs counted 611,000 on its registry. By 2001, the registry had risen to 690,000, of whom 397,000 (58 per cent) lived on-reserve or on crown lands and 293,000 (42 per cent) lived off-reserve (Department of Indian and Northern Affairs, *Registered Indian Population by Sex and Residence 2001* [Ottawa, 2002], available online: [www.ainc-inac.gc.ca](http://www.ainc-inac.gc.ca)).



The Indian/non-Indian life expectancy gap has declined since 1975. Better Aboriginal access to health care is one explanation. HEALTH CANADA PHOTO

from traditional activities. By the 1996 census, more than seven in ten among the Aboriginal-identity population lived somewhere other than on a reserve; half lived in cities. Among registered Indians, over 40 per cent now live off-reserve, many of them also in cities (see box for definitions of terms).

Non-Aboriginal Canadians undertook analogous change, but their ancestors did so over the course of a millennium or more. Given the speed of Aboriginals' transition, it is not surprising that they have experienced a great deal of social distress, including worse health outcomes than among other Canadians. More eloquently than can I, Chief Dan George summed up the effect of this "upheaval":

*I think it was the suddenness of it all that hurt us so. We did not have time to adjust to the startling upheaval among us.*

*We seemed to have lost what we had without replacement for it. We did not have time to take our 20th century progress and eat it little by little and digest it. It was forced feeding from the start and our stomachs turned sick and we vomited.*

Life expectancy is a statistic that summarizes the impact of all factors – quality of health services, incidence of communicable and noncommunicable diseases, mental illness, health-damaging “lifestyle factors” – that bear on mortality. Early in the 20th century, life expectancy at birth among Indians was significantly lower than among other Canadians. Over the second half of the century, the Indian/non-Indian life expectancy gap declined. In other words, Indian life expectancy improved, both absolutely and relative to that for non-Indians.

Between 1975 and 1990, for example, the gap among men fell by 3.9 years; among women, by 4.9 years. Much of the lowering of the gap was due to the improvement in Aboriginal access to health services. Indicative of the importance of access, the Indian/non-Indian infant mortality gap has continuously declined.

Since 1990, something has changed – at least among Indian men. Over the 1990s, the male life expectancy gap remained nearly stable; it declined by only 0.7 years. Among women, the rate of closing of the gap also slowed but, by 2000, the gap had declined a further 2.0 years.

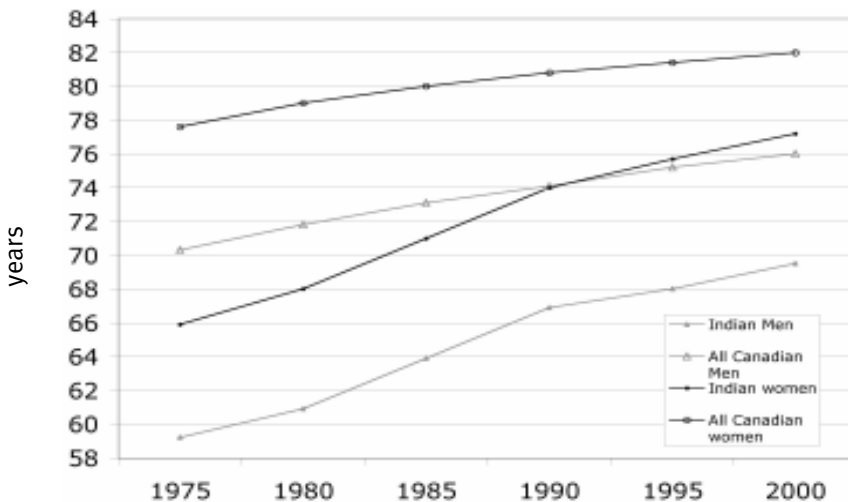
Some differences in provision of health services persist, but I doubt this explains much of the remaining gap. In a recent Statistics Canada report, Michael Tjepkema notes the rise of “new” diseases such as diabetes and cardiovascular disease, diseases formerly rare among Aboriginals (table 1).

Why the rise of these diseases? Here is Tjepkema’s explanation:

*It is thought that the rise of these ‘new’ diseases ... can be attributed to the rapid social, dietary, and lifestyle changes experienced by some Aboriginal communities over this period. These health inequalities are explained, in part, by the fact that Aboriginal people have lower socio-economic status than other Canadians, a characteristic that is widely known to be associated with poor health.*

I agree that “rapid social, dietary, and lifestyle changes” are the proximate explanation. Tjepkema goes on to suggest that the ultimate explanation is low socioeconomic status. I have difficulty with this argument. However measured, the social status of Aboriginals was undoubtedly lower in 1975 than now. If low status is the key independent variable, why were these “new” diseases not previously prevalent?

**Figure 1: Life expectancy at birth, Indians and all Canadians, by gender**



Source: Calculated from data in Department of Indian Affairs, *Basic Departmental Data – 2000* (Ottawa, 2001).

Perhaps Tjepkema is right, but there are other ways of looking at the evidence. Many of the lifestyle changes associated with poor health outcomes are associated with abandonment of traditional hunting and trapping activities and adoption of a more sedentary lifestyle, something made feasible by ease of access to social transfers (such as social assistance and Employment Insurance). In the second half of the 20th century, particularly the last quarter, Ottawa and the provinces greatly expanded social programs for all Canadians – and, unlike in earlier decades, these programs were available to Aboriginals. By the late 1980s, two fifths of on-reserve Indians were in receipt of social assistance, a statistic that has not changed much since. In the context of low formal education and limited income potential from traditional economic activities, ease of access to social transfers acted as a massive inducement to change lifestyle and

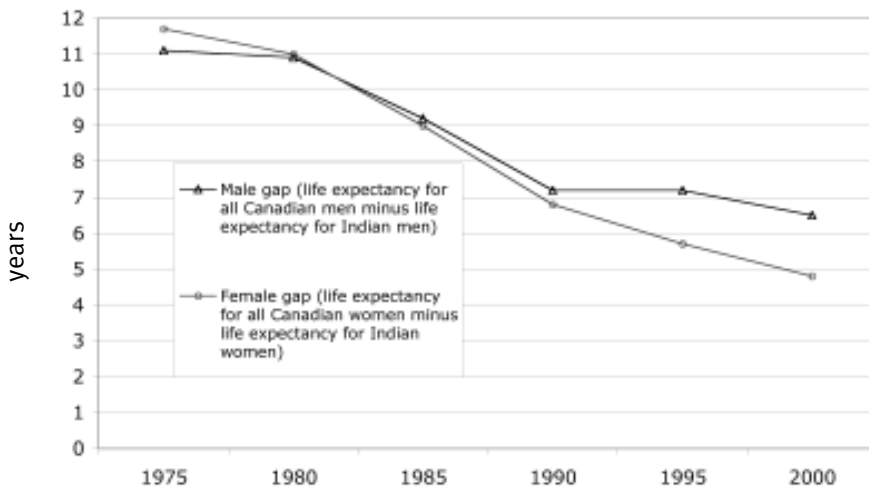
rely on transfer income. Better access to health services improved health outcomes; increased reliance on transfers did not. Whatever the source of family income, women engage in the work of raising children; the negative health effects of abandoning hunting and trapping activities have probably been more acute for men.

## The importance of work

Work has many benefits beyond the obvious one of generating income (in cash or in kind). Another way of saying this is that non-work induces a more sedentary lifestyle (which increases incidence of heart disease), more obesity (which affects heart disease and diabetes), and more depression (which increases depression-related causes of ill health, such as domestic violence, alcohol and drug abuse).

Two qualifications should be made. First,

**Figure 2: Life expectancy gaps, by gender**



Source: Calculated from data in Department of Indian Affairs, *Basic Departmental Data – 2000* (Ottawa, 2001).

regardless of race, rural isolation lowers the probability of finding productive employment yielding incomes above levels available via social transfers. And despite migration to cities in recent decades, Aboriginals are more likely than non-Aboriginals to live in isolated rural communities.

The second qualification concerns the interplay of reasons that induce Aboriginals

to abandon formal schooling. (About two thirds of non-Aboriginals have a high school diploma or better; about one third of on-reserve Aboriginals do. Among off-reserve Aboriginals, high school completion rates are roughly halfway between the two other rates.) Improved education increases the employment rate because it opens the door to better-paying jobs, whose incomes unambiguously exceed the income to be derived from welfare or EI.

The two qualifications are not independent. It is more costly per student for governments to organize schools in isolated rural areas than elsewhere, and harder for principals in rural schools to maintain a high-quality teaching staff. Hence, on the supply side of education, rural schools are often less effective than urban schools: fewer specialized programs and higher teacher turnover rates. And on the demand side, if students expect to live in an isolated rural environment with a low probability of regular employment, they perceive a low reward from investing in education.

If an excessive reliance on transfer income explains some (much?) of the racial differences in lifestyle factors affecting health, then the politically sensitive question must be asked: is it a good idea for Indian Affairs to award large transfers to band councils, roughly a quarter of which are devoted to welfare payments, and thereby fiscally bias Indians to choose to live on-reserve? Why not award at least some treaty benefits to individual Indians, and allow them to choose freely whether

**Table 1: Health Status , Aboriginal and non-Aboriginal Canadians**

	Aboriginal	non-Aboriginal
	<i>Age-adjusted prevalence</i>	
<b>Chronic conditions</b>	(per cent)	
<b>Heart problems</b>		
Male	13	4
Female	10	4
<b>Diabetes</b>		
Male	11	3
Female	16	3
<b>Injury rates, 1996–97</b>	(rate per 100,000)	
Manitoba Aboriginals	117	
Sask. Aboriginals	142	
B.C. Aboriginals	185	
Canada		28
<b>Suicide rates, 1996–97</b>		
Manitoba Aboriginals	21	
Sask. Aboriginals	19	
B.C. Aboriginals	38	
Canada		13
<b>HIV/AIDS</b>	33.2	3.1
	<i>Prevalence over age 15</i>	
	(per cent)	
<b>Smokers, 1997</b>	62	29

Source: Health Canada, *A Second Diagnostic on the Health of First Nations and Inuit People in Canada* (Ottawa, 1999). Available online: [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)



One of the “new” diseases afflicting Aboriginals is diabetes. Key to reducing its prevalence is a healthy diet. HEALTH CANADA PHOTO

to live on a rural reserve or in an urban industrial milieu, as do most Canadians? This argument underlies the case for “updated treaty money” made by Jean Allard in the 2002 issue of *Inroads*.

Since off-reserve Aboriginals fare better than on-reserve ones in terms of education and income, by extrapolation we should expect better off-reserve health outcomes. To my knowledge, there is no good evidence to confirm that Aboriginal health status is better off- than on-reserve. It must immediately be added that urban Aboriginal conditions are far from ideal. As Tjepkema documents, off-reserve health outcomes are worse than those of non-Aboriginals. Urban Aboriginals are overrepresented in very poor neighbourhoods with ghetto-like characteristics: low employment rates, high reliance on welfare and so on.

If the Romanow Report broaches the social determinants of Aboriginal health outcomes, I hope it stresses the importance of work. There are two arguments I would like to see:

- **Healthy reserve communities require adequate employment opportunities for those Indians who choose to live on them.** This implies that treaty negotiations and court interpretations of existing treaties concern themselves more with the potential for on-reserve employment, and less with the magnitude of income transfers. For example, in British Columbia where treaty negotiations are subject to high-profile debate, the focus should be not on Aboriginal claims to royalty income from crown-owned resources but on access to resources with employment potential.

- **In general, off-reserve migration is probably a desirable trend in terms of health outcomes, but both Ottawa and the provinces could do much more to improve off-reserve Aboriginal education outcomes and limit long-term Aboriginal reliance on social assistance.** A combination of aggressive provincial campaigns to lower Aboriginal high school dropout rates and to assure more restrictive access to welfare (among both Aboriginals and non-Aboriginals who are deemed employable) would, in the medium term, generate significantly higher Aboriginal employment rates – and better health outcomes.

## Health care delivery problems

Social determinants are key to explaining Aboriginal health outcomes. However, the way Aboriginal health programs are delivered matters as well. Administrative ad hocery within Health Canada is acute and is itself a part of the problem.

Widespread incidents of corruption and poor management among band councils have received a good deal of attention. In response, the Department of Indian Affairs has launched a high-profile First Nations Governance Initiative intended to improve the ability of ordinary band members to hold their respective chiefs and band councils accountable. Not surprisingly, the Assembly of First Nations (AFN), an organization representing chiefs and councils, interprets this as an unwarranted intrusion on the Aboriginal right to self-government. At the time of writing, senior officials in the relevant agencies concerned with Aboriginal policy – Indian Affairs, Health Canada, the Privy Council Office and Finance – are debating all this.

What I think fair to conclude about this debate is a reluctance to address a painful truth. In general, band councils are small (more than 600 bands across Canada, with an average on-reserve population below 600) and cannot discharge adequately the expansive list of activities currently under their purview. They are even less capable of undertaking the more ambitious agenda put forward by the AFN. There is a need for pragmatic alternatives to the status quo. However, few in the senior reaches of the federal government are prepared to engage these matters, either openly or in private. The result is an unhealthy self-censorship in public and, behind closed doors, an ideologically constrained policy discourse.

The First Nations and Inuit Health Branch has posted the following “vision” statement to its website: “First Nations and Inuit people will have autonomy and control of their health programs and resources within a time-frame to be determined in consultation with First Nations and Inuit people.” While qualified, this implies evolution toward increased institutional separation of health services, as advocated by the AFN. The reality, as privately acknowledged by some senior officials and politicians, is an unsatisfactory accretion of ad hoc measures. In summary, here are some of the problems:

- **Bands are organizing health services under bewildering financial arrangements that preclude accountability for outcomes.** Ottawa assumes responsibility for financing all health services for on-reserve Indians. Whether this is a discretionary decision flowing from Ottawa’s jurisdiction over Indians or whether this is a constitutionally entrenched treaty obligation is unclear. Actual pro-



If Aboriginal children are to have a fair chance at leading healthy lives, fetal alcohol rates must be cut. HEALTH CANADA PHOTO

vision of health services for Indians is usually undertaken by agencies not under federal jurisdiction. In some instances, bands directly hire health care workers who provide services for on-reserve band members; in other cases, bands or Indian Affairs contract with the relevant province to provide services. The channels for financing these services are convoluted. Some spending is undertaken directly by Health Canada; some is undertaken by bands using funds transferred from Health Canada; some is

undertaken by provinces subject to reimbursement from Health Canada; some is undertaken by individual care providers subject to reimbursement from Health Canada. In this context no one is effectively responsible for spending; no one can redirect resources in the interest of better outcomes.

- **Band councils face severe adverse political pressures on their health budgets.** All governments are subject to pressure to use health budgets for purposes not directly related to health services – for example to fund inefficient hospitals so as to maintain jobs. On-reserve unemployment and poverty make this

pressure particularly acute. The result may be excessive length of patient hospital stays, weak accounting control on health expenses and so on.

- **Health Canada faces rapid escalation in Aboriginal health spending.** Like provincial finance ministries concerned with rapid overall health budget increases, the federal Department of Finance is concerned with the rapid escalation in federal Aboriginal health expenditures, in a context where administrative complexity and political sensitivities

render exercise of fiscal controls and value-for-money auditing exceedingly difficult.

- **Differences in insured health services add to interracial tension.** For registered Indians, both on- and off-reserve, Ottawa provides so-called noninsured health benefits (e.g. for dental services). These are insured services not available to other Canadians. More generous insured health services for Indians than for non-Indians may be interpreted as a treaty benefit; they may be a matter of discretionary policy. In either case, the status quo generates tension among non-Indians, who pay taxes and yet receive less generous insured health services. How serious this sense of unfairness is, I am reluctant to speculate.

## What's to be done?

Here I consider four broad options for health care delivery reform.

### 1. Extrapolation of the status quo.

While the status quo presents many inadequacies, major improvements in Aboriginal access to health services have taken place. These improvements have come about as a result of good-faith endeavours by Health Canada, band councils, provincial health departments and individual care providers.

This option avoids the political conflict inherent in each of the remaining three. The obvious disadvantage is that it ignores the serious inadequacies in the status quo, as discussed above.

**2. Devolution to bands or to regional councils of local bands.** This entails explicit interpretation of Indian health benefits as a treaty obligation and transfer of

administrative control over the spending of funds to band councils. To avoid some of the problems with health planning undertaken by small individual bands, responsibility might be transferred to regional councils representing multiple bands within a geographic area.

This option would be popular with the AFN. However, it would do little to relieve the identified problems of the status quo: adverse political pressures, convoluted financial channels and racial tension due to different groups of citizens receiving different insured health benefits. Not to mention that the history of interband cooperation on such matters is dismal.

### 3. Reassertion of the federal role in provision of health services for Indians.

Ottawa could create its own health delivery capacity by hiring health care providers. It would allow Health Canada to play an active role in delivery of health services to a particular group of Canadians. It would also be an occasion to exercise affirmative action in employing Aboriginal care providers.

It could lead to some standardization of insured services among Indians and elimination of the convoluted channels of financing services that currently exist. It would be unpopular with the AFN and with most provincial governments. The provinces are insistent on their primary jurisdiction over delivery of health services. This option would not enable easy integration with delivery of services to non-Indians.

**4. Transfer of responsibility for delivery of on-reserve health services to provincial governments.** I come to my preferred option. To an extent, it is merely descriptive: as more Indians live off-reserve, the provinces have become more involved

in provision of Aboriginal health services. To realize a more formal integration of services, it would require political sensitivity from the provinces and a breach in the AFN tradition that Indian bands deal “nation to nation” with Ottawa, not with provinces.

The arguments for this option are in part administrative: a higher potential for integrated planning to maximize quality of health services for all residents of a province, elimination of present convoluted financial channels for financing health care providers and so on. Defence of this option implies a more subtle thesis: that provision of insured health services is an aspect of government activity that should be undertaken in a manner transparently equal to all, independent of race.

Were the provinces to assume responsibility for provision to all citizens within their respective boundaries, it would require some preliminaries:

- The provinces might require Ottawa’s endorsing the principle that treaty benefits do not entail insured health benefits more generous than are provided to other Canadians.
- The provinces would insist on transfers of fiscal capacity from Ottawa to reflect the additional costs of providing health services to on-reserve Indians.
- Ottawa could insist that bands exercise an advisory role at the provincial level, and Ottawa could monitor to ensure that provinces assume “successorship” responsibilities over arrangements whereby bands currently exercise influence over certain health budgets.

Alan Cairns has rehabilitated the term “citizens plus” used in an important federal study conducted in the 1960s (the Haw-

thorn report). Indians have a legitimate case for a “plus” component to public policy but, Cairns contends and I agree, we are currently in danger of ignoring the “citizen” component. Both components matter. In a subsequent article published in *Inroads*, Cairns succinctly stated his concerns:

*The Aboriginal future is within Canada, for both Aboriginal peoples living in cities and those living in organized communities. This ... means ... that Aboriginal peoples are not only Canadians, but are and should be thought of as such by others and by themselves. This was the argument of the Hawthorn survey a third of a century ago, restricted by its terms of reference to the legal status [i.e. registered] Indian population. Citizens Plus is an attempt to revive the necessity and relevance of the citizen component, which I see as threatened by a policy discourse that pays more attention to how we can be kept apart than to what will hold us together. My fear is that an exaggerated stress on “otherness,” on incommensurable solitudes, on a multinational definition of who we are, may lead us to treat each other as strangers with little moral obligation to help each other.*

Cairns does not explicitly address health programs, but there are few dimensions of our “moral obligation to help each other” more important than government-financed health services. This dimension is under stress in all industrial countries, as a result of changing health technology and simultaneous public expectations of better service and no increase in tax rates. It is, I conclude, a component of what needs to be part of the minimum content of shared Canadian citizenship – across races and across provinces. ■

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