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Résumé de l'article

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Abstract

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Keywords

Indigenous healthcare, Indigenous health policy, First Nations and Metis Health and Well-being, Manitoba, Community-engaged Research, Access to Care, Governance, Self-determination, Soft Rights, Reconciliation

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The Future of Indigenous Healthcare in Manitoba: Moving Beyond Soft Reconciliation in Health

The delivery of healthcare services in the province of Manitoba has undergone a series of revisions over the past 25 years as provincial demographics, economy, and population needs change. Beginning in 1997, Manitoba moved to regionalize the delivery of healthcare services with the creation of Regional Health Authorities. However, after 20 years operating in that structure, the provincial healthcare system was found to be too complex, creating barriers for people to access services (Manitoba Ministry of Health, Seniors and Active Living, 2018b). The regionalized structure allowed for duplication and healthcare planning that operated in silos with little coordination between regions and provincial health organizations. Provincial healthcare funding increased by 97% between 2003 and 2016, however significant health improvements were not observed (MHSAL, 2018b). As a result, Manitoba remains one of the lowest-ranking provinces across many health indicator areas (MHSAL, 2018b). The experience and burden of poor health outcomes has been especially the case for Indigenous peoples in Manitoba.

Manitoba has the highest proportion of Indigenous people relative to the provincial population among the ten provinces of Canada. In 2016, there were 223,310 Indigenous people in Manitoba, making up 18% of the population. Within Canada, there are over 630 First Nation communities, which represent more that 50 distinct Nations and languages (CIRNAC, 2021). Manitoba has 63 First Nations, including six of the 20 largest communities in Canada. The province also includes the largest number of Red River Métis people per capita in Canada with the majority living in southern Manitoba, including the city of Winnipeg. The Métis in Canada have a unique combination of identity, values, language, and cultural traditions that distinguish them from the other two Indigenous groups of Canada, (First Nations and Inuit). Métis is "a person who self-identifies as Métis, is distinct from other Indigenous peoples in Canada, is of historic Métis Nation ancestry, and is accepted by the Métis Nation" (Métis National Council, 2023). Despite a diverse, resilient, and growing population, Indigenous peoples in Manitoba experience a greater burden of illness and face numerous health inequalities compared to the general population. Consistent findings across many studies have indicated that Indigenous people face substantially greater mortality and morbidity rates and poorer self-rated health compared to other Manitobans. They can expect to live eight years less than other Manitobans and the rate at which they die young is especially troubling. They are three times more likely to be hospitalized for injury (Martens et al., 2010). Currently, youth suicide has become a significant concern in the prairie provinces for First Nations and Métis youth (Tait et al., 2017). In Manitoba, the crude proportion attributed to "violence to self" (i.e., suicide) is higher for Métis youth than for all other Manitobans (Martens et al., 2010). Indigenous children and youth are vastly overrepresented in child welfare settings and young offender facilities. High involvement in both systems are proven to show an increased propensity for individuals to be involved in provincial and federal adult corrections. The result of residential schools and the subsequent 'Adopt Indian and Métis' policies of the 1960s and 70s has helped to create cycles of intergenerational trauma that today's youth continue to carry forth in violent ways onto themselves and others (Blackstock & Trocmé, 2005; Bombay et al., 2014).

Jurisdictional ambiguity and the lack of clarity on the roles and responsibilities of the federal and provincial government with respect to health services to Indigenous Peoples continues to be a challenge.

Indeed, this ambiguity persists through the ways in which governments approach reconciliation, a process that the Canadian state has declared as a priority in state-Indigenous relations. For reconciliation to be meaningful, tangible and practical actions must be undertaken, honouring the roles and responsibilities, including to Indigenous health, that the state has historically committed to.

Despite the high numbers of Indigenous people living off-reserve, the province of Manitoba continues to take the position that they bear no responsibility for supporting health programs because Indigenous people fall within federal jurisdiction and thus should be served through federal funding and programming. Although the Manitoba government is required to provide equal access to health care services under the Canada Health Act, an Act that sets out the primary objectives of Canadian health care policy, for all residents of Manitoba including First Nations living on reserves, it continues to take the position that the federal government is responsible for certain health services to First Nations people who are Status Indians under the Indian Act. The Indian Act is the primary Canadian federal legislation used to administer First Nations status, establish local First Nations governments, and direct the management of reserve land. As a result, some health services not covered by the Canada Health Act but otherwise provided by the provinces through the Regional Health Authorities may or may not be provided to First Nations communities (Boyer, 2003). These disputes create ongoing tensions that translate into complex program fragmentation, problems with coordinating programs, under-funding, inconsistencies, service gaps, and lack of integration (Lavoie & Dwyer, 2016). Additionally, policies fail to adequately address the health care needs of the Métis, First Nations and Inuit people who are either not registered or not living on reserve or in their traditional territory.

The purpose of this article is to provide an overview of the history of state responsibility for Indigenous health through policy. This article offers community narratives of the very real health outcomes and experiences of First Nations and Métis peoples within the province of Manitoba where jurisdictional ambiguity persists, and practical reconciliation remains unrealized.

An Overview of Health Transfer Policy

This research evaluates the federal Health Transfer policy, which was implemented in 1989, in order to solve 20 years of consultation and discussion between Indigenous Peoples and the federal government on the more appropriate ways to deal with inequalities existing between First Nations Peoples and the rest of Canada (Lavoie et al., 2008). The federal government presented the policy as a positive effort to meet the demands for autonomy and band-level control of healthcare services (Culhane-Speck, 1989). The Policy offers First Nations south of the 60th parallel a significant opportunity for enhancement of local capacity and culturally appropriate health planning and delivery. These services were to be delivered through the First Nations Inuit Health Branch (FNIHB). In April 1986, an Interim Report from the Sub-Committee on the Transfer of Health Programs to Indian Control was distributed to the First Nations, presenting Health Transfer to appear very desirable. It was stated that "The Branch is proposing a developmental approach to transfer centered upon the concept of self-determination in health" (Department of Health and Welfare Canada, 1989). It further suggested that communities would determine their own needs and make decisions about how services would be developed and managed and would be free to take into consideration their own traditional, cultural, and practical

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circumstances (Department of Health and Welfare Canada, 1989, p. 6). The Health Transfer Policy was and remains defined in a two page document that most closely resembles a statement of intent.

The Health Transfer Policy envisioned the transfer of existing community-based and regional services to a single community, or a group mandated by the community (Department of Health and Welfare Canada, 1989). Health transfer enables communities to take on the administration of a range of community-based and regional programs. The process includes the transfer of knowledge, capacity, and funds so that communities can manage and administer their health resources based on their community needs and priorities (Health Canada (FNIHB) 2003). The majority of transfers have occurred in single communities that range from less than 200 to 10,000 residents, with an average of around 500 (Health Canada, 2003). The final policy was not as detailed and flexible as suggested in the interim report because it did not include non-insured health benefits (NIHB), dental, environmental health, or training in Transfer (Culhane-Speck, 1989). In light of the rhetoric of self-determination that was part of the development and marketing of the Health Transfer, this research demonstrates that the policy has done little in the way to enhance local capacity in health governance, administration, and reconciliation within Indigenous communities.

Additionally, provincial policies and health systems fail to adequately address the health care needs of the Métis or First Nations and Inuit people who are either not registered or not living on reserve or traditional territory. This leaves considerable gaps in the way that healthcare is designed and delivered to meet the unique health needs of these communities, to the detriment of Indigenous health and contributing to furthered inequities and health disparities. The Métis Nation is currently pursuing their right to have their healthcare needs addressed by the Federal government. However, to date, Métis peoples and communities are not recipients of Federal Health Transfer. Métis communities across the homeland receive healthcare services the same way that other provincial or territorial residents do, through provincial or territorial health systems.

The provincial healthcare system and service delivery within Manitoba has been under review for over two decades, as demographics within the province have changed along with the state and nature of the economy and population. Following such review, the province recognized the need to respond to growing changes through health system transformation, which has traditionally not considered the existence of health transfer policies between the federal government and First Nations within Manitoba, or acknowledged where these agreements are not in place.

Healthcare System Transformation in Manitoba

In response to increasing provincial healthcare expenditures, and a lack of corresponding improved health outcomes, the Manitoba government commissioned a series of studies and reports between 2012 and 2017 to evaluate the state of the healthcare system. These studies evaluated all aspects of the system, from emergency departments (EDs) and services, to wait times and sustainability. Recent change to Manitoba's healthcare system rests on the findings of four central government commissioned reports produced between 2013 and 2017. Overall, these reports resulted in a series of recommendations to change and ensure sustainable delivery of healthcare services while improving the health of Manitobans. Recommendations for improvement included the need to close or amalgamate low-volume EMS

stations primarily located in rural areas across the province, increase service integration and patient-centered care, and most significantly, the establishment of a single, centralized provincial health organization. While the reports and their recommendations speak to the provincial population and healthcare system, one report for example, prioritized Indigenous health, stating that Indigenous communities would benefit from a strategic alignment with the province in health service delivery. In the same report, the author (Peachey, 2017) recommended service consolidation where possible, often meaning within rural, remote and northern areas with large Indigenous populations. These reports and recommendations fail to acknowledge the specific health needs of First Nations living off reserve, where the Federal government is responsible for service funding, and Métis communities across rural and Northern Manitoba.

Early in 2012, the provincial government recognized that changes were required to address the delivery of emergency medical services (EMS) including ambulance and paramedical care, and patient transfer. An independent consultant was commissioned by the government to undertake a review of EMS delivery across the province, and the resulting report found that a more integrated, reliable, and sustainable emergency response service was needed to address long wait times and distances (Toews, 2013). The 2013 Review also recommended the closure of nearly two dozen low-volume EMS stations, most of which were rural or remote (Laychuk, 2017a). The province assured residents that only EMS stations with very low call volumes, in poor state of repair or significant staffing shortages would be closed and that these closures would result in a more responsive and coordinated emergency medical response service (Government of Manitoba, 2017b). One of the major limitations to implementing the report recommendations included the siloed, multi-agency, provincial healthcare delivery system, which contributed to a lack of coordination, confusion, and duplication of services (Toews, 2013). The healthcare system would have to be addressed at large by the province in order to improve EMS services and healthcare delivery more broadly, across Manitoba.

In 2016, the newly elected conservative government called for a series of studies on the healthcare system, which is by far the most expensive provincial expenditure in Manitoba. Fiscal responsibility, reform and sustainability were highlighted as central to the provision of services going forward and therefore research into improved healthcare systems delivery, improved access to quality services and increased provincial healthcare planning was deemed necessary. The result of this research called for a centralized healthcare system, and in 2017 the province took a step forward towards transforming the system with the creation of Manitoba Shared Health, a provincial health organization (PHO) that would improve planning and increase integration of healthcare services within Manitoba. One of the major initial changes to healthcare service delivery following the establishment of the PHO was the previously suggested change in EMS delivery, leading to the questionable closure of some EMS stations across the province. One such station was located in the rural settler community of Grandview, located alongside a rural hospital and 24 hour ED, which provided primary and emergency healthcare services for the nearby First Nation and Métis communities. Interestingly, this particular station did not meet the province's stated criteria for closure, and both settler and Indigenous residents in the area were left confused and concerned for the future of their health and health services in their communities.

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Indigenous Health Policy and "Reconciliation"

Health has never received the kind of attention from public policy scholars that other aspects of Indigenous self-determination have generated. Because the urgent need to improve the economic situation of Indigenous Peoples logically underlies all other questions, scholars have given these debates the most attention. It would seem that improvements in health, through changes to the health care system, are not likely to be as dramatic in the absence of more basic changes in the socio-economic position of Indigenous Peoples (Waldram et al., 2006). We argue that some of the changes related to health policy definition and delivery are just as important as the longer standing ones related to economic development and constitutional arrangements.

This research helps identify some of the gaps in knowledge by focusing on two critical healthcare gaps in the province: the federal health transfer policy, a policy that continues to be counterproductive to Indigenous health and well-being; and the province's intended closure of Grandview's EMS station and its failure to consider First Nations and Métis perspectives and access to care. While the Government of Manitoba has expressed their commitment to moving forward with reconciliation, the province continues to contribute to the broader discourse and political imaginary around reconciliation that minimizes Indigenous health sovereignty and self-determination of Indigenous Peoples. This soft version of reconciliation emphasizes the adoption of political changes that support the increase of Indigenous rights and nationhood largely in relation to Indigenous culture and socioeconomic equality at the expense of substantive reforms that include changes to health care that would implement territorial power-sharing and self-determination. While the analysis in this research is a selective one, it is intended to contribute to a broader discussion about the future of Indigenous healthcare, self-determination, and reconciliation efforts in the province of Manitoba.

A Community Profile of Tootinaowaziibeeng Treaty Reserve and San Clara Métis

The Manitoba community discussed in this article is Tootinaowaziibeeng Treaty Reserve (TTR) which is a signatory to Treaty #4. TTR encompasses southern Saskatchewan as well as a small western portion of Manitoba and southeastern Alberta. Treaty #4 contains no health-specific provision. A Medical Officer associated with the Department of Indian Affairs was, however, present at the time the Treaty was signed to provide medical treatment to Indians assembled for the signature (Lavoie et al., 2010). TTR was part of the West Region Tribal Council which services seven First Nation communities but has since decided to become independent of the Tribal Council. TTR is situated 400km northwest of Winnipeg, Manitoba and 38km east of Roblin, Manitoba. TTR is also immediately situated adjacent to the provincial Duck Mountain forestry, and 24km westward of the Municipality of Grandview, Manitoba. It is considered a rural reserve and geographically speaking is not close in proximity to any major city centres as Roblin and Grandview each have a population under 2,000. The TTR overall population is 1283 (On/Off Reserve) with 616 residing on reserve, and 661 residing off reserve. The health funding they receive from Health Canada is specific to the on reserve population only.

TTR has experienced many health challenges within their community including issues with their youth, drug and alcohol abuse, increases in chronic disease and mental health concerns. Many TTR residents do not have access to adequate shelter for their needs, which we define as housing that protects from the

harsh climate, that fosters human dignity and emotional well-being and that would support (rather than undermine) health. Housing on TTR is viewed in the community as a serious issue of health, justice, and human and Indigenous rights. While the community experienced TB epidemics in the early and mid-twentieth century, they have not experienced any recent cases; however, many community members have expressed concern regarding the potential for crowded housing's risk for possible future epidemics of infectious diseases, including influenza (Gabel, 2011).

Currently, unlike many other First Nations across Manitoba, the community of TTR is able to access primary and emergency medical services efficiently and effectively through the local healthcare system within the town of Grandview. Access to healthcare services is a significant determinant of Indigenous health, and many Indigenous peoples experience inequalities which restrict that access (Adelson, 2005). These services are sought by residents in addition to the healthcare services offered on reserve in the community health centre, such as public health nursing, diabetes services, home care, and addictions prevention as part of federal health transfer. The nearest physician and hospital for both non-emergent and emergent care is the Grandview Hospital, located approximately 23 minutes from TTR. Grandview's EMS responds to between 46% to 93% of all calls out of TTR, consistently arriving within 30 minutes, making it the most reliable and dependable emergency medical response centre of all municipalities surrounding TTR. This is important, as TTR is a rural First Nation, with a singular access road in and out of the community. With Grandview's EMS responding to the majority of calls, paramedics have become familiar with the reserve community and roadways, arriving on the scene in the shortest wait time possible. Additionally, three primary and emergency care physicians provide services to patients from TTR within the Grandview Hospital and clinic. Residents of TTR are thus able to access quality healthcare services through the provincial healthcare system nearby to their community.

Grandview's hospital and EMS is also accessed by members of the San Clara Métis community, located 86km northwest of Grandview. While healthcare services including primary and emergency care can be accessed more locally within the nearest settler community of Roblin, some San Clara residents choose to travel a greater distance to receive what they consider more responsive, personable and reliable care in Grandview. Such health decisions are critical, where Métis people residing within Manitoba experience poorer health status that that of other Manitobans, and most mortality measures are found to be between 14 and 23 percent higher among the Métis (Martens et al., 2010; 2011). San Clara represents a particularly small but historic Métis settlement, composed mostly of older adults. Without community-based care through a health clinic or nursing station, San Clara residents rely on provincial health services for all of their healthcare needs.

Methods

This project is grounded in over a decade of Community-Engaged Research (CER) within the province of Manitoba. Chapter 9 of the TCPS 2 provides a definition of community engagement, as "a process that establishes interaction between a researcher or research team, and the Indigenous community relevant to the research project" (CIHR, 2010). The TCPS 2 states that community engagement is a collaborative relationship between community and researcher; however it acknowledges that there are varying degrees of collaboration depending on the community context and the nature of the research (CIHR, 2010). Engagement may include review and approval from formal leadership within the

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community to allow the research to be conducted, or extend as far as community empowerment and shared leadership on the project, or the community may not actively engage at all beyond approval (CIHR, 2010). The TCPS 2 states that an Indigenous organizational community can participate in research that is focused on its members, such as the board, or staff, or it could facilitate ethical engagement with the population that it serves (Powell, 2014; Powell & Gabel, 2018). Nation et al. (2011, p. 89) define CER as "a collective approach to research that democratically involves community participants and researchers in one or more phases of the research process." Stoecker and colleagues (1992, 1999, as cited in Nation et al., 2011, p. 90) state that the purpose of CER should be to "democratize knowledge and resist oppression." Furthermore, Nation et al. (2011) identify another division in CER with community initiation, where the community organizes itself to address a need and then seeks the involvement of researchers, and community collaboration, where the researcher connects with the community to collaborate in answering a research question. The key benefit of CER is a deeper understanding of a community's unique circumstances, and a more accurate framework for adapting best practices to suit the community's needs. In our research, particular attention was paid to supporting an ongoing effort to integrate both community and researcher perspectives in all stages of the research process. This process included over a decade of community-engaged, qualitative research with Tootinaowaziibeeng Treaty Reserve (TTR), the Métis community of San Clara, and the settler community of Grandview in western Manitoba. The researchers developed relationships with community members and disseminated findings back to the community. Methodologically and analytically, the researchers followed knowledge pathways articulated and experienced by participants through semi-structured interviews, focus groups, and sharing circles. Archival research in pursuit of published and unpublished position papers, reports and policy documents also formed the foundation necessary for this research. The overarching goal of the research was to provide a holistic overview and understanding of the ongoing healthcare system transformation and policy processes across the province, and to understand the effects of these policy changes on both communities.

From 2010–2020, the researchers conducted over 50 semi-structured interviews, focus groups, and sharing circles in TTR with Indigenous and non-Indigenous community members and key actors and leaders with the intent of exploring the changing nature of Indigenous health policy and politics in the community. Here, the researchers focused on the health transfer policy, a policy intended to improve health at the community level by supporting the development of community-based and culturally appropriate health programs. The researchers found that TTR, like many Indigenous communities in Manitoba and elsewhere, have struggled with the constraints put on them by the federal and provincial levels of government. From 2018–2020 within the municipality of Grandview, Manitoba, the nearest municipality to TTR, this community-initiated study consisted of 29 semi-structured interviews with residents, stakeholders, and service providers within the community and surrounding area. This inquiry aimed towards understanding the state and experiences of healthcare services available to residents of Grandview and San Clara, and members of TTR prior to a significant provincial health system transformation, which is set to include the closure of Grandview's EMS station. The researchers found a stark absence of community consultation in the development of a new provincial health system, including consultation with both rural municipalities and affected First Nations and Métis communities. This study finds that confusion and discrepancies in responsibility for Indigenous health in Manitoba between provincial and federal government creates and sustains existing inequalities in access to

healthcare among Indigenous Peoples. Failure to include the perspectives and impacts of change on rural residents and TTR and San Clara community members demonstrates a lack of government dedication to consultation and reconciliation.

Relationships

This project resulted from the communities discussed in this article reaching out to one of the authors who is Métis from a neighbouring community in Manitoba to help write a community health needs assessment, five year community health plan and major report. Key leaders and actors approved the research and put in place MOUs and research agreements. Ethics approval was also secured from the authors' University's Research Ethics Board.

Results

The Health Transfer Policy

The TTR leadership, residents, and health administrators are not optimistic about the health transfer process and feel that the policy and associated programs perpetuate a system of colonialism, racism, and state-run operations. These views are described below:

> The government is all over the map, they speak of self-determination and health, but there's nothing cohesive with self-determination because health transfer is a set agreement. But yet they call it a partnership [Community Member]
>
> Realistically, FNIHB is not dealing with the issues, they're dealing with what's on the table already so they're accepting that as a starting point when it shouldn't be. So, if people understand what's there, then you might have more vocal support behind those issues. [Health Service Provider]
>
> The health programs should be able to service off reserve membership as well. Because it is your membership so in my opinion somebody should be going after Health Canada for the residency requirement of on versus off reserve. You're not allowed to sequester opinions from off reserve people, that's discriminatory. There's an inherent bias in the system. [Community Member]
>
> We have to always remember that FNIHB is the banker, that's where we get our money from and until that changes, they are going to continue to influence our future. [Health Service Provider]

The Government is increasingly requiring more and more data that demonstrate the successful rate of programs, particularly in the area of health. These success rates dictate whether or not programs get funded or cut and thus a tremendous amount of pressure is placed on the communities to make their programs successful. There has also been greater government demands for financial reports as communities are continuously audited. This is a source of much frustration for administrators and health service providers. One could make the argument that this collection of information which includes constant reporting and includes establishing community health needs assessments and community

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health plans every five years is a mechanism in which the government flexes its control over Indigenous communities. In no other part of Canadian society are health administrators required to follow these types of processes. Thus, while the Indigenous health policy arena has undergone major transformation in Canada, Indigenous Peoples continue to place themselves in historical continuity with many years of struggle against colonization and oppression. They see current government policies as fracturing Indigenous identities on both a personal and collective level:

> I don't expect the federal or provincial government to change, you know. They're continually trying to exert jurisdiction, they are continually trying to capitalize on our resources, totally disregarding our relationship to the land in terms of trading relationships and our Aboriginal rights. So, we're in for, you know, ongoing struggles, things are going to move slowly [Chief].

Despite the challenges, many communities also speak about resiliency, the strengths in their community, and the importance of self-determination in health:

> I have a great deal of faith and I think that our community is strong and everybody's moving at a different pace and growing and developing. Some communities are very clear about where they want to go, and others are moving in that direction. [Health Service Provider].

> I think our community is highly resourceful and we don't want the status quo, we want to have good health and access to services just like any other Canadian. That's all we want. Getting there has been a long road for us, it can be troubling and not clear because there are just so many other things going on. [Community Member].

> Community-controlled health for us is being self-determined and when you're completely governed on your own. Maybe we haven't reached that, but I think these are exciting times, I think these are very exciting times. [Health Administrator].

> We have started the process of having a nurse practitioner come in from Grandview to run women's health clinics which is a very positive thing. We really need to set aside our differences and start from the basic building blocks to make our community healthy again. We need to learn to partner with each other before we can expect to develop partnerships outside of the community. [Health Service Provider].

Forty years ago, Indigenous people were choosing illness and death rather than deciding to face the mainstream health care system out of a fear that they would encounter racism and discrimination. Subsequently, community controlled health policies were developed to combat some of these issues (Weaver, 1990). Although the challenges Indigenous people face with the healthcare system are well documented (Allan &Smylie, 2015) and continue to exist, the achievements and resiliency described above have been extraordinary.

Impacts of Healthcare System Transformation in Grandview and TTR

The implementation of healthcare system transformation within Manitoba created significant impacts on rural and Indigenous communities and Peoples across the province. In Grandview and the

surrounding area, confusion about the intended closure of the local EMS station and hospital was exasperated by a total lack of communication from the provincial government. For example, in 2017, during a series of community meetings regarding the newly announced EMS closures, Grandview residents, members of TTR and local Métis people voiced their concerns over EMS wait times (Laychuk, 2017b). A proposed new EMS station out of the neighbouring community, Gilbert Plains, would now respond to Grandview and the surrounding rural area, potentially taking longer to arrive on scene than an EMS vehicle out of Grandview (Laychuk, 2017b). In community meetings, residents were expressly concerned that prior to the announced closure, there had been no community consultation, of either Grandview residents, Métis people, or members of TTR (Laychuk, 2017b). As one community member stated to the CBC, "The Conservative government made a big deal about being consultative before they got into office… They've made some major changes without asking the people who are going to be affected," (Laychuk, 2017b, p. 1). These sentiments, voiced in early community meetings in 2017, were echoed again in interviews with Grandview residents, as one participant stated, "the government needs to do the footwork [in the community] before making serious changes." One participant called this type of government change, "dehumanized decision-making" referring to the use of statistics and cost-analyses data to inform critical and life-changing decisions regarding the healthcare system and the communities that may lose services. One health service provider elaborated:

> The government was looking at paper and demographics [when they made their decision], not at individual community needs. I mean, we have it all here! …they need to re-evaluate and look at the communities that are being affected. There are always variables [that get missed when relying on statistics]. They need to see the full picture... they did not make an informed decision.

Many community members and service providers felt that TTR and other First Nations across the province were not appropriately considered or consulted as to their needs and the impacts that proposed changes would bring to their community. As one stakeholder stated, "there are over 600 First Nations living [in TTR], and they are put at risk if [the ambulance] is not able to arrive from Roblin within 30 minutes… clearly with the government, Toot[inaowaziibeeng] was overlooked." Another service provider who works between Grandview and Tootinaowaziibeeng stated commented on this lack of community consultation, and how service provision within the rural community and First Nation has been successful:

> They [the government] absolutely ignore Valley River [Tootinaowaziibeen]. If they even knew Valley River existed, right, and even an inkling of worrying about them, they wouldn't have done that. But they worry about a [settler] community that's smaller than Valley River… I think they need to take a close look at what works, and why it works. And say, 'this is something that's been going for a while, and this is something that works, and why don't we… make that strong?' Yeah, there's so much we could do here, and our patients are so happy to be treated here, they hate going to [the city]. They just want us to do everything we can for them here. So, the communities are totally accepting of local care, but you've got to give us the tools.

Similarly, community members within San Clara remarked on the lack of inclusion and opportunity to participate in decision-making that will ultimately affect their health outcomes, and in some cases, survival. As one community member remarked:

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> I suspect the government's decision to close this region's health spaces are because they can get away with it. There are a small number of votes in the region and it is well known that… much of the political power, populace, and infrastructure stays in southern Manitoba… I would like to see a cooperative, consolidated joint effort between the Métis Nation and the provincial government to take responsibility to address these [health] concerns… Those who will be more seriously impacted by these [policy] changes will be those in the lowest economic brackets… those whose families no longer live in the community… and who are otherwise alone will also experience a diminishing quality of life… I firmly believe the inequities in health and wellbeing will worsen as a result of these changes.

Discussion

"Reconciliation" in Indigenous Health

The Canadian government continues to champion practical reconciliation, or what Sheryl Lightfoot refers to as soft rights, i.e., rights related to language and culture, while systematically denying "hard rights," such as rights to land and health (2010, p. 62). In the eyes of successive governments, soft rights or what we refer to as soft reconciliation, is equated with partnerships in which non-Indigenous and Indigenous Peoples should work amicably toward specific, realizable goals and objectives. Health has become a key area of soft reconciliation. Under community controlled health policies, Indigenous and non-Indigenous people involved in health politics are pioneers of intersectoral and intergovernmental policy collaboration. Their efforts yield tangible, quantifiable outcomes. Examples of achievements include: 100% success rates of immunization programs, lower rates of hospitalization, decreases in rates of infectious disease and better chronic disease management (Gabel, 2011). In all of these developments, however, there is an expectation by government bureaucrats, public health policymakers and others that Indigenous peoples and their communities accept mainstream values that do not radically challenge non-Indigenous people's conceptualization of reality. Similarly, Glen Coulthard has described reconciliation politics in Canada as helping to "fabricate a sharp divide between Canada's unscrupulous 'past' and the unfortunate 'legacy' this past has produced for Indigenous people and communities in the present" (2014, 121). Thus, reconciliation in Indigenous health has been framed in a way that negatively portrays or excludes representations of stories or issues that intersect with Indigenous sovereignty and territorial claims, while conversely focusing on positive representations of issues and stories emphasizing cultural accommodation, programming, and socioeconomic development.

The government's emphasis on soft reconciliation is experienced by community health workers as essentially patronizing:

> Publicly they [the government] say that they are committed to Aboriginal health and care about us and that they support us but in our last evaluation with them, they closed down our files and froze our funding ... after a year of paperwork, they told us that our transfer report to them was not very comprehensive and not easily readable. The fact that they can just close our files and freeze our transfer funding ... it's wrong. [Healthcare Provider]

> They [the government] say, we recognize culture and tradition, but they really don't because they say, 'well, you can do what you want in regards to culture and tradition'. I say 'well, no you can't'. Their thought is well, hire a Native person and you have culture. If you can't hire a Native person, because there are not a lot of Native nurses around then you have to hire a non-Native nurse and they're not sensitive to the culture. And so when you look at the issue of suicide as an example, I want to bring our traditional people, but the problem is there is no funding for that because they're [the government] prescriptive. [Health Administrator]

In the recent process of healthcare system transformation, the Manitoba government has failed to acknowledge the current federal health transfer agreements and services in place within First Nations and other Indigenous communities across the province. Thus, the provincial system fails to address community needs and inequalities that currently exist. For TTR, the impending loss of EMS services within the neighbouring community of Grandview has led to uncertainty regarding the ability to access timely emergency and potentially life-saving care. Many residents reflected on their fears, suggesting that without reasonable access to quality emergency healthcare, residents may elect to take their health into their own hands, by trying to help themselves, or by not doing anything at all. For example, one participant simply stated, "people may come to avoid seeking help, seeking services, if they feel they cannot access them." Further, we found that TTR was not consulted in any way regarding health system transformation, while the province continued to state that affected communities would be engaged throughout the transformation process.

At the time of publication, Health Transfer continues within First Nations communities, and services within Grandview remain in place. Many Indigenous communities are committed to advocating for community control over health care services, in part an effort to eliminate the legacy of jurisdictional confusion. Many discussions have taken place in the past few years on the need for Indigenous health transformation. The COVID-19 pandemic has highlighted the urgent need for this transformation. However, work so far has not addressed the central issue, the unresolved barriers to self-determined reconstitution of First Nation and Métis health governance based on Indigenous sovereignty. Over the course of the COVID-19 pandemic, emergency services, hospital services, and the community clinic in Grandview were repeatedly closed and reopened due to provincial decisions on pandemic response and human resource allocation. Each time these closures occurred, community members feared that this would be permanent, as the province avoided providing First Nations, Métis and rural communities, and health care providers with clear timelines and objectives in their response to the pandemic. The examples provided within this article serve to exemplify the urgent need to address these barriers, and a need to move from soft, inauthentic reconciliation in health care to practical, meaningful, Indigenous-led actions and outcomes. There clearly remains a long way to go under the current Conservative leadership of the Manitoba government, where ambiguity and disregard for responsibility in delivering accessible health care is still the status quo.

Government attempts towards reconciliation through Indigenous health policy are often lackluster due to the fractured and complex system through which healthcare services are delivered to Indigenous peoples across Canada (Gabel et al., 2017). This is unfortunate, but expected. In the case of EMS service withdrawal from Grandview, TTR was never consulted by the province, because the Manitoba

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government does not perceive the delivery of EMS services to First Nations as a provincial responsibility, leaving the community in a precarious position. There are examples however, of provincial health care delivery within First Nations reserve communities, such as in British Columbia where the First Nations Health Authority operates, where communities and regional health authorities collaborate to deliver health services. Future research in this realm of Indigenous health and policy should evaluate and compare the experiences of First Nations communities receiving care on reserve through Health Transfer, through the provincial health system, and those First Nations empowered to self-determine health care services within their community.

It comes as no surprise that governments limit the degree of Indigenous communities' independence with respect to the design, delivery, and evaluation of health services. Government departments are held accountable to Cabinet and ultimately to the Canadian public for the money that they spend, Indigenous health expenditures are therefore scrutinized closely. A tension is created between outcomes and processes. There is a desire on the part of the government for health outcomes that will stand up to public scrutiny and improve provincial rankings in health. At the same time, they know that they must work amicably with Indigenous communities. Government departments and bureaucrats are constantly seeking ways to establish practical partnerships with communities. But concurrently, they try to avoid more complex discussions of jurisdiction, Indigenous self-determination, and hard rights to health. In contrast, Indigenous people view reconciliation as an opportunity to reinterpret Canada's colonial history and to recognize Indigenous peoples' hard rights to healthcare. Indigenous political advocates argue that reconciliation and Indigenous self-determination must go hand in hand. Reconciliation should bring about changes to bureaucratic structures and should challenge non-Indigenous peoples' values. Health system and service decisions at the provincial level cannot be made without Indigenous involvement, and partnership with federal and provincial counterparts.

These are two notable examples from within the province of Manitoba that demonstrate the complexities that exist and persist within the delivery of Indigenous healthcare in Canada and at a global level. Here, the delivery of improved healthcare services are intended to result in improved Indigenous health outcomes, an indicator of successful reconciliation efforts between settler states and Indigenous Peoples. With specific reference to Indigenous health policy recommendations, the TTR and Grandview cases discussed above suggest that provincial governments responsible for the delivery of healthcare services to all residents, must actively consult and engage honestly and authentically with Indigenous communities. This must include First Nations on reserve, Métis peoples, and Indigenous people living in urban settings, to thoroughly plan, develop and implement system changes. This research further argues that these changes can and should only be made with the expressed support and consent of Indigenous communities, utilizing evidence produced by communities themselves. Lastly, provincial governments must undertake a strengths-based approach to healthcare systems and policy change, recognizing community capacity for change, and by empowering community involvement throughout the process. By doing so, governments, alongside Indigenous Peoples and communities, may engage in positive and effective changes that bring about improved health outcomes.

Conclusion

It is not surprising that reconciliation and self-determination in Indigenous health progresses at a very slow rate when up against colonial institutions, structures, policies, and practices. In the past two years alone, other major services have been affected by change in the name of sustainability, ultimately affecting the safety and access to healthcare services for rural and Indigenous Peoples across the prairies. The COVID-19 pandemic had Indigenous communities across the nation bracing themselves for the virus spreading from urban centres to rural and remote communities. Prime Minister Justin Trudeau warned that should an out-of-town visitor contract the virus in a rural area, they may find that they can't access treatment as easily as they would have been able to had they stayed in a larger city. Additionally, transportation across Central and Western Canada was altered in July 2018 when Greyhound announced that it would cease to operate western routes across Canada, effectively severing public transportation connections between rural and remote communities across half the county (Hutchins, 2018). This change has been seen by many as a move to cut rural Canada off from the growing world of urban centres (Hutchins, 2018). More immediately, loss of service across the prairies means a lifeline to critical health and social services has been severed, preventing people who rely on them from accessing necessary services that can only be found out-of-town in larger centres (Hutchins, 2018). For instance, these cuts will have major implications for Indigenous Peoples and communities. The final report from the National Inquiry into Missing and Murdered Indigenous Women and Girls recommended “more frequent and accessible transportation services available to Indigenous women, girls, and LGBTQ2S people” (Government of Canada, 2019). These cuts will exacerbate the risk, vulnerability, and potential violence against Indigenous women and girls. Moreover, there will be a significant reduction in access to much-needed health services.

Our research reveals that there has been a clear case of bureaucratic confusion within Manitoba over the past decade, and further, that this ambiguity and lack of clarity regarding responsibility for Indigenous healthcare services puts communities at risk of experiencing continued inequality. With federal Health Transfer taking place within many Indigenous communities, in the form of diverse, community-led programs and services, it is critical that the provincial government actively consults with each First Nation and Métis community and to consider where gaps exist in access to care, and to effectively fill them. Doing so is a step towards reconciliation that moves beyond soft rights and recognizes Indigenous peoples’ hard right to health, regardless of neo-colonial bureaucracy and harmful debates on government jurisdiction.

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