



# BRIEF



## Access for all? Fact or fiction...

**Presented to**

**The Committee on Health and Social Services  
National Assembly of Quebec**

**by**

**The Assembly of the First Nations  
of Quebec and Labrador (AFNQL)**

**and**

**The First Nations of Quebec  
and Labrador Health and Social  
Services Commission (FNQLHSSC)**



# Access for all? Fact or fiction...

*Joint Brief, presented November 12, 2013.*

**Addressed to:**

The Committee on Health and Social Services,  
National Assembly of Quebec

In the context of the special consultations for the document entitled:

*"AUTONOMY FOR ALL: White Paper on the Creation of Autonomy Insurance"*

**By:**

The Assembly of the First Nations of Quebec and Labrador (AFNQL)  
and

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*States shall consult  
and cooperate  
in good faith  
with the indigenous peoples  
concerned through  
their own representative  
institutions in order  
to obtain their free,  
prior and informed consent  
before adopting  
and implementing legislative  
or administrative measures  
that may affect them.*

**Article 19 - United Nations  
Declaration on the Rights  
of Indigenous Peoples  
(UNDRIP)**

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## INTRODUCTION

In 1985, the Assembly of the First Nations of Quebec and Labrador (AFNQL) opened its doors and created a forum to bring together the Chiefs of 43 communities representing 10 First Nations from Quebec and Labrador. The AFNQL discusses a number of issues: the defence of Aboriginal titles as well as Aboriginal ancestral and treaty rights; federal and provincial government policies that undermine their traditions and ways of life; government laws and regulations and relations with the two levels of government; economic development as well as social, economic and cultural issues; issues regarding self-government; federal government relations and international relations. The AFNQL Secretariat coordinates priority files and outreach activities for the Regional Chief, and executes the decisions reached by resolution by the Chiefs in assembly with a view to improving the living conditions of First Nations.

The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) is an unincorporated, not-for-profit organization that is mandated to support the efforts of the First Nations of Quebec and Labrador to, among other things, plan and deploy preventive and culturally appropriate health and social service programs. Since its founding in 1994, its mission has been to promote and ensure the physical, mental, emotional and spiritual well-being of First Nations and Inuit individuals, families and communities. The FNQLHSSC also aims to foster access to comprehensive health and social services programs that are adapted to First Nations, designed by recognized organizations and sanctioned by the local authorities, while respecting cultures and local economies.

This Brief, presented jointly by the AFNQL and the FNQLHSSC, begins by providing an overall portrait of the situation experienced by the First Nations of Quebec. This portrait is key to understanding the differences between First Nations and non-Aboriginals in terms of historical context, living conditions, and the organization and delivery of health and social services. The subsequent section will explore the issues specific to First Nations as well as the First Nations' position on the question of autonomy insurance. The conclusion will offer recommendations for ensuring that First Nations have access to care and services that are comparable to those enjoyed by the general Quebec population. Note that for the purposes of this Brief, the portrait of First Nations was completed using information from 32 First Nations communities in Quebec<sup>1</sup>.

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<sup>1</sup> Does not include data from Cree and Inuit villages.



## OVERALL PORTRAIT OF THE SITUATION

### *a) Socio-demographic characteristics and living conditions of Quebec First Nations*

In 2012, there were 87 091 First Nations members on record, of whom 68.0% lived in one of the 41 communities spread out across Quebec. People aged 65 years and older represented 6.2% of this population; people aged 85 years and over, 0.4%.

According to Statistics Canada, the life expectancy for First Nations men will be 73 years in 2017, that is, 6 years less than their Canadian counterparts. As for First Nations women, they will have a life expectancy of 78 years, compared to a life expectancy of 83 years for Canadian women. This gap can be explained by the less favourable living conditions of the Aboriginal people of Canada<sup>2</sup>.

In terms of data on disabilities, in the policy entitled "À part entière pour un véritable exercice du droit à l'égalité," adopted on June 4, 2009, the Quebec government stated the necessity of documenting the situation of people living with disabilities in Aboriginal communities. "There is no recent documentation on their condition in Quebec; most of the data that is available is on Canadians. This is proof that these people can be subject to marginalization and discrimination. It is absolutely crucial that we obtain an accurate portrait of the situation of people living with disabilities and living in Aboriginal communities in Quebec in order to find a way to adequately meet their needs." [translation]<sup>3</sup>.

Recently, the FNQLHSSC submitted a report entitled "Portrait of First Nations in Quebec Living with Disability or Having Special Needs." The findings of this report showed that almost one-quarter (22.9%) of First Nation adults living on reserve declared living with at least one disability. In fact, among the adults living on reserve, the proportion of people who declared having a disability increased systematically with age. Specifically, respondents between the ages of 18 and 29 were the least likely to report living with a disability (13.1%), whereas the proportion of people living with disabilities was highest among those aged 60 years and older (49.7%).

In terms of education, the Quebec First Nations Regional Health Survey, published in 2008 (see Appendix 2 for key findings) revealed that nearly 82.0% of seniors aged 65 years and over did not complete their secondary school education. As for revenue, the personal income of 70.0% of adults aged 65 years and older was under \$20,000, and 42.4% of seniors stated that their total household income was less than \$20,000 in 2007.

The average size of households in First Nations communities in Quebec is 4.3 residents per dwelling, compared to 2.5 residents per dwelling among the general Quebec population. Moreover, 15.0% of seniors in First Nations communities live in overcrowded housing. Note that overcrowding leads to psychological tensions and violence, and fosters the transmission of infectious diseases such as tuberculosis and Hepatitis A.

<sup>2</sup> Statistics Canada, Projections of the Aboriginal Populations, Canada, Provinces and Territories, 2001 to 2017 (online), <http://www.statcan.gc.ca/pub/89-645-x/2010001/life-expectancy-esperance-vie-eng.htm>, consulted on October 29, 2013

<sup>3</sup> Gouvernement du Québec, "À part entière pour un véritable exercice du droit à l'égalité," 2009



Furthermore, the quality of more than half of the dwellings in these communities is deemed inadequate, and the percentage of people who live in housing that requires major repairs went from 24.7% in 2002 to 27.5% in 2008<sup>4</sup>.

### ***b) Historical overview of the health and social services accessible to the First Nations of Quebec***

The Constitution Act of 1867 assigned the exclusive authority over "Indians and the Lands reserved for the Indians" to the Canadian Parliament.<sup>5</sup> For this reason, the federal government intervenes in First Nations communities in all sectors of activity, particularly with respect to funding and bolstering basic health and social services, in tandem with the Quebec system. Provincial laws of general application (e.g. health services and social services, health and safety standards applicable to buildings) are applicable on reserve territory until they are replaced by a law or federal regulation, or until the band council responds by adopting its own regulation.<sup>6</sup> The band councils, to exercise the powers that were conferred onto them by the Indian Act, have created a number of services in areas such as health and social services, public infrastructure and housing, public safety, etc.

To ensure that people with special needs or reduced autonomy enjoy adequate living conditions, it is crucial that they be secured access to health and psychosocial care and services, as well as home care services. In 1979, the Canadian government adopted the Indian Health Policy,<sup>7</sup> which aims to increase the level of health in First Nations communities using means that were conceived and maintained by First Nations. Specifically, the goal of this policy is to "achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves." This goal rests on three pillars: "community development," "the traditional relationship of the Indian people to the Federal Government," and "the Canadian health system."<sup>8</sup>

In 1986, the federal government introduced the *Health Transfer Initiative*<sup>9</sup>. As a result of this initiative, the administrative authority for community health services was transferred to First Nation band councils. However, the federal government continues to fund several types of services, including health services and social services. More specifically, two complementary programs are in place to provide services to seniors.

The first program, deployed by Health Canada in 1999, is the First Nations and Inuit Home and Community Care program (FNIHCCP). This program provides funds for essential services, such as nursing care, personal care, needs evaluation, case management, in-home respite care, and access to equipment. The second program, deployed by Aboriginal Affairs and Northern Development Canada (AANDC), is the Assisted Living Program, which renders non-medical social support services to assist people with reduced autonomy by funding in-home support services, adult foster care and institutional care.

<sup>4</sup> FNQLHSSC, First Nations Regional Health Survey (RHS 2008)

<sup>5</sup> The Constitution Act, 1867, R.S.C. 1985, Appendix II, n° 5, s. 91(24)

<sup>6</sup> See Sébastien GRAMMOND, "Terms of Coexistence: Indigenous Peoples and Canadian Law", Carswell, Toronto, 2003, pp. 361-377; Michel DESCHÊNES, "Les pouvoirs d'urgence et le partage des compétences au Canada" (1992) 33 Les Cahiers de Droit, pp. 1181, 1203-1205

<sup>7</sup> FNQLHSSC, *Assessing Continuing Care Requirements in First Nations and Inuit Communities — Quebec Regional Report*, 2006, p. 14

<sup>8</sup> Health Canada, [http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli\\_1979-eng.php](http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php)

<sup>9</sup> FNQLHSSC, *Assessing Continuing Care Requirements in First Nations and Inuit Communities — Quebec Regional Report*, FNQLHSSC, 2006, p. 15



### **c) Description of the organization of the service offer and available programs**

In the majority of First Nations communities in Quebec, the health centres primarily offer community health services during office hours, according to available funding. A nursing station is open 24/7 in each of the 11 communities that are considered remote. These nursing stations provide emergency care and manage community health programs. All health care services, in particular services offered through the First Nations and Inuit Home and Community Care program (in-home nursing care and personal care), are funded by Health Canada, with the exception of services rendered by physicians (permanent or visitor), which are reimbursed by the Régie de l'assurance maladie du Québec<sup>10</sup>. The funding of complementary care and services (e.g. nutrition, rehabilitation, respiratory therapy, psychology, palliative care) is based on the service delivery plan adopted by each community, developed according to its specific needs and available funding. With service delivery thus organized, people who require specialized services are often required to travel outside the community to another institution in the Quebec health system, unless these services are periodically rendered within the community by visiting professionals, when possible.

As for social services, the AANDC funds several programs, including adult placement services, housekeeping and home management (to complement the home care program funded by Health Canada), as well as seven (7) residential facilities for people with decreased autonomy who require less than 2.5 hours of care per day (ISO-SMAF [functional autonomy] profile of nine [9] or less). Note that facilities providing health and social services in Aboriginal communities are not considered to be part of the Quebec health system, even though several of these community facilities are operated under a private institution permit issued by the Ministère de la Santé et des Services sociaux du Québec (MSSS).<sup>11</sup>

Second- and third-line health and social services, including treatment that requires hospitalization or long-term placement, are offered by the Quebec health system.

Furthermore, as per the Canada Health Act, Quebec receives a Canada Health Transfer and a Canada Social Transfer, which assures a portion of the necessary per-person funding for the health services and social services on its territory, the delivery of which falls under provincial jurisdiction. All First Nations of Quebec are included in the calculation of these transfers.

### **d) Home care needs among the First Nations of Quebec<sup>12</sup>**

According to the data collected through the RHS, close to half (48.2%) of people aged 75 years and over receive home care; this proportion stands at 32.0% for people in the 65-74 age group, and 8.1% for people in the 55-64 age group. Although the use of home care, as well as the need for home care, increases with age, 5.1% of people in the 18-54 age group report needing home

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<sup>10</sup> Ministère de la Santé et des Services sociaux, *Delivery and Funding of Health Services and Social Services for Aboriginal People*, 2007, p. 7-8

<sup>11</sup> *Ibid.*

<sup>12</sup> RHS, *op. cit.*, note 5, chapter 17, *Home care*, p. 9-10



care. Approximately three-quarters of home care recipients declare having two or more chronic health problems. The most commonly reported health conditions are hypertension, arthritis and diabetes.

Of the people who report needing home care services, less than half (46.4%) receive them. Of the people who report needing home care and often experiencing physical or mental constraints or health problems which limit the nature or number of their domestic, professional or other activities, close to one in five (17.4%) do not receive home care services.

The factor of geographic isolation appears to have an impact on access to home care services: The gap between needs and access to home care services is approximately three times wider in hard-to-access communities than in communities located in urban areas.

Close to half (48.5%) of people who provide home care services to a loved one or immediate family member are between 35 and 54 years of age, and a little more than half (56.6%) are women. One informal caregiver in five spends more than 20 hours per week providing home care, 5.4% of whom spend more than 40 hours per week doing so. Half (51.6%) of the people who provide care or assistance to a friend or family member have access to support through the services offered in their community.

Given that several First Nations communities do not have long-term care facilities, most people who require such services must leave their community. The median age at the time of placement in out-of-community long-term care facilities is 68 years, and chronic health conditions, such as diabetes and neurological conditions, are the main reasons prompting these placements.

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<sup>13</sup> AFNQL Resolution no. 11/2013 is appended to this Brief.



## ANALYSIS OF THE SITUATION

The Quebec Minister of Health and Social Services, who is also the Minister responsible for Seniors, has proposed a plan for autonomy insurance that would provide assistance to people with diminishing autonomy and to seniors to help them remain in their living environment as long as possible. This plan could be implemented as early as the spring of 2014. Despite espousing a very admirable objective, the proposed bill represents a major source of concern for First Nations.

As illustrated in the portrait, the situation of the First Nations of Quebec who live in their communities is unique; they cannot be simply grouped together with the rest of the Quebec population. And yet, upon close examination of the Quebec government's White Paper, it is clear that the project, which addresses the general Quebec population, has not given any consideration to the special circumstances faced by the First Nations or the potential impact this project could have on their communities and existing service offer. Indeed, the First Nations governments were not approach for consultation. In a resolution adopted unanimously,<sup>13</sup> the AFNQL has declared it necessary to obtain more information on autonomy insurance so that it may be analyzed. Through this resolution, it has also upheld the importance of involving First Nations in developing the parameters of the future bill.

For the purposes of this Brief, three (3) major issues have been defined and will be presented in the following order:



### **Issue 1:**

In its White Paper, the Minister introduces a new approach to offering adapted, long-term health and social services to people living with significant and persistent disabilities due to their age or disability.<sup>14</sup> He proposes to bolster and build on the current CSSS service offer by increasing accessibility to home care and services for a greater number of beneficiaries, and granting a more significant role to CSSSs throughout the different phases of local autonomy insurance implementation.

In this new model, the CSSSs' responsibilities would include service coordination, service quality oversight and the organization of health and social services within their respective jurisdictions.

<sup>14</sup> *Autonomy for all: The Autonomy Insurance Project*. <http://www.autonomie.gouv.qc.ca/en/assurance-autonomie>

<sup>15</sup> It is possible that services offered by the Quebec health system be available in communities, either in accordance with special agreements concluded with the Quebec system or to meet the needs of non-Aboriginal residents.



As previously mentioned, basic care services are offered in the communities and are managed by the band councils or other institutions recognized by the First Nations' governing authorities through funding provided by the federal government. The Quebec health and social service system thus plays a complementary role that is primarily focused on offering support services that are generally not offered in First Nations communities<sup>15</sup>. The autonomy insurance project proposes to mandate the CSSSs to, among other things, develop service plans, which is a responsibility already assumed by personnel operating the health centres in the communities. In the event where the autonomy insurance project is applied to the communities' territory, it will be necessary to determine the impact of sharing these responsibilities, competencies, and resources.

With the financial involvement of another party—the health and social agencies—in the provision of care or services in the private residences of seniors, a certain amount of confusion surrounding the roles and responsibilities of all parties is expected upon the implementation of autonomy insurance. As such, collaborative and administrative procedures should be proposed and determined in advance.

Finally, should the proposed autonomy insurance be made available to First Nations living in their communities, what measures will the federal government put in place in response to those changes? The communities have the right to access services that are equivalent to those received by the general Quebec population, and this right cannot be hindered by the fear that the federal government could withdraw funding from its programs. The federal government must assume its fiduciary responsibilities, whereas the administration of programs in the communities must fall within the autonomous jurisdiction of band councils. In this light, it becomes clear that an analysis must be conducted to determine the impact of autonomy insurance on the sharing of responsibilities between the federal, provincial and First Nations governments.

The autonomy insurance project does not contain all the answers to the questions and concerns put forth by the First Nations. In fact, the project does not even allow for the possibility of asking such questions. Moreover, the project does not specify whether there are plans to introduce provisions to account for the sharing of responsibilities between the federal and provincial governments. In the context of this project, there has been no recognition of the right of First Nations to political and administrative autonomy, nor has there been any assessment of the current needs of First Nations communities. This, despite the fact that the Quebec government has previously recognized in a declaration of principles that Aboriginal nations have the right to have and control, within the framework of agreements with the government, institutions that correspond to their needs in matters of culture, education, language, health services, social services and economic development.<sup>16</sup>

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<sup>16</sup> Source: Secrétariat des affaires autochtones (SAA), in reference to the 15 principles that guide all government involvement in Aboriginal affairs, which were adopted on February 9, 1983, by the Cabinet .



## **Issue 2:**

The Minister hopes to begin rolling out autonomy insurance in the spring of 2014. The White Paper posits that the project will have to be implemented through three transition phases, which will be managed concurrently. During the first transition phase, resources and services will be transferred to the person's place of resident; the White Paper highlights that these services must be well-planned, organized and coordinated. Given the upcoming deadline, it is reasonable to assume that plans to reorganize resources under the Quebec health and social services system are well underway, and perhaps even finalized in certain respects. It is also reasonable to assume that the necessary health and social service workers and other resources will shortly be mobilized to meet the needs of new clients when the time comes.

However, to what extent will the measures be able to ensure a rapid response to the needs of First Nations communities in terms of basic professional care and services, assistance for activities of daily living (ADL) and instrumental activities of daily living (IADL)? As demonstrated above, the communities have access to a service offer that, while more restricted in range, is similar to the one offered by the Quebec system; it is funded by the federal government and managed by the band councils or other institutions recognized by the band councils.

It thus follows that the MSSS should recognize the role already played by the service offer in the communities as well as the legitimacy of their existence. The MSSS should refrain from making a unilateral decision to transfer resources from the Quebec health and social service system in order to bolster the service offer in the communities. Despite this, the White Paper, by making absolutely no reference to the First Nations, appears to propose just the opposite.

The implementation of this type of project must take into account any existing service offer and align its organizational efforts around those of each community, which may vary greatly from one community to the next. The powers of band councils responsible for managing the health and social services in First Nations communities must be respected and recognized.

Note that communities are constantly trying to improve the quality of their services and to make sure these are adapted to the cultural reality of their clients. The fact that communities are responsible for these services rather than the government authorities is the best guarantee that beneficiaries will receive culturally-adapted services. Moreover, these types of services do not preclude compliance with recognized norms and standards nor the use of tools such as the Multiclientele Assessment Tool and the iSMAF software. Rather, these tools are regularly used by community workers to evaluate the needs of service recipients and of people who must be admitted to private residences for seniors or other institutions in the Quebec system. In fact, the FNQLHSSC has been offering community workers training on these tools since last year thanks to funding from the AANDC.

As for the quality of services offered through autonomy insurance, given that these services are meant for a particularly vulnerable clientele, is the MSSS prepared to improve service delivery in English for the English First Nations communities of Quebec?

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<sup>17</sup> An Act Respecting Health Services and Social Services, ss. 509 and 510



Although the Quebec government has already committed to improving access to services for the English population—as evidenced by the obligation of each health and social services agency to adopt an access program for services in the English language—it would make greater strides in achieving this objective by offering training in English (e.g. training for informal caregivers and other care or service providers), particularly in regions bordering Ontario and New Brunswick, and by ensuring the participation of representatives from English First Nations communities in provincial and regional committees<sup>17</sup>.

The special linguistic needs of communities will have to be taken into consideration, both at the level of services offered to the population and throughout the various strategic and decision-making forums designed to ensure quality. This request is regularly made by First Nations.

Should communities decide to adhere to the project, would the community organizations or salaried individuals who already offer home care and services with support from the band council receive formal authorization by the CSSS to have the right to receive a salary under the proposed structures of autonomy insurance? The current legal structure of these organizations do not meet the MSSS' requirements. Does this not present the risk of creating competing services—namely, those offered by the service providers recognized solely by the band council as opposed to the services provided by the institutions accredited by the MSSS? How should we proceed to coordinate these services in a way to ensure their effectiveness, and what do the beneficiaries stand to gain? This is yet another facet that the MSSS must consider.

According to the White Paper, the second transition phase for the autonomy insurance project relates to moving from a health care system designed for a young population towards a system structured based on the needs stemming from an aging population. This transition may correspond to Quebec's demographic trends, but First Nations' demographics show a much younger population than the Quebec average, and younger populations have different needs. Without additional funding, it would be difficult for the communities to modify their health and social services offer to prioritize seniors; as a result of chronic underfunding, the communities already struggle to meet the needs of those under the age of 30.

### **Issue 3:**

This issue bears on the proposed funding mechanisms for autonomy insurance and the impact these mechanisms could have on the specific fiscal framework that applies to First Nations.

For the third transition phase, the White Paper states that the government intends to ensure the availability of a protected funding mechanism. Until 2017-2018, the funding will be assured by the following three components:



- A fiscal framework, indexed annually by the federal government, to which \$500 million will be added to cover the anticipated increase in home care services.
- User fees corresponding to amounts that are not refundable by the Tax Credit for Home-Support Services for Seniors, as well as the amounts users are required to pay into the Financial Assistance Program for Domestic Help Services (FAPDHS) and a portion of the contributions made for adult placements in CHSLDs.
- Fiscal expenditures equal to the increase in the Tax Credit for Home-Support Services for Seniors.

When determining the fiscal framework for autonomy insurance, did the Quebec government take into consideration the needs of First Nations communities? Does it intend to fund the estimated increase in home care and support? If so, it would be interesting to know how these factors were accounted for given that the communities were not consulted about their needs.

Moreover, it would be difficult to deploy the FAPDHS program in the communities because it imposes conditions that are often contrary to usual practices, particularly in terms of subcontracting.

The Tax Credit for Home-Support Services for Seniors, funded by the Quebec government, is available to seniors aged 70 and over. Unfortunately, the health of First Nations in many communities deteriorates much more rapidly than that of non-Aboriginals as a result of poverty and deplorable socioeconomic conditions. Because seniors require care services at an earlier age and places are limited in long-term facilities, which moreover exist but in a few communities, there would be a greater access to care if people under the age of 70 were eligible for the Tax Credit for Home-Support Services for Seniors.

In the long term, the funding for autonomy insurance is slated to rest on a financial reserve (autonomy fund) made up in part of indexed budgets that will be allocated to home care. However, it has yet to be determined how supplementary funding will be secured to meet the growing needs as of 2017-2018. Regarding this matter, the White Paper simply states: "This means having sustainable, stable and permanent funding on into the future." It offers no meaningful solution, even though the necessary funds in question are substantial and could amount to a total of \$1.9 billion during the 10 years following 2017-2018.

The search for a source of long-term supplementary funding to cover the growing costs of MSSS services is reminiscent of the Quebec government's efforts, in 2010, to ensure the sustainability of the public services offered by the health system, namely by introducing tax measures in the form of mandatory health contributions. This contribution was unilaterally imposed on First Nations, who are still contesting its application and evoking their exemption from taxes as per section 87 of the Indian Act.



## CONCLUSION

The autonomy insurance project, as presented in the White Paper, completely ignores the existence of First Nations, as well as their historic and inherent rights, specific socioeconomic conditions, the powers they have the right to exercise and the responsibilities of both levels of government. This project was designed solely in keeping with the reality that characterizes the aging Quebec population and the weight the resulting needs will place on the health system and the organization of services. It does not take into account a number of major issues faced by First Nations communities. Should the project proceed in its current form, it would be impossible for First Nations communities to accept the Quebec government's project for autonomy insurance.

Before even considering implementing this type of project in First Nations communities, it is crucial that the impact on First Nations institutions first be analyzed in depth. The First Nations must have the opportunity to develop measures that are adapted to the real needs of their populations, in a way that respects their cultures and their rights. To account for these special circumstances, the future bill to implement autonomy insurance in Quebec will have to be elaborated in collaboration with the First Nations.

The Quebec government must be reminded of its commitment to consult the First Nations: "Were the Government to legislate on matters related to the fundamental rights of the Aboriginal nations as recognized by Quebec, it pledges to consult them through mechanisms to be determined between them and the Government"<sup>18</sup>.

All consultative processes must be subject to prior discussion between the parties concerned in order to determine the structure and mechanisms of consultation. The establishment of such a practice is justified not only by the complex nature of intergovernmental and socioeconomic issues, but also by the distinct status of the First Nations of Quebec.

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<sup>18</sup> Source: Secrétariat des affaires autochtones (SAA), in reference to the 15 principles that guide all government involvement in Aboriginal affairs, which were adopted on February 9, 1983, by the Cabinet .



**Access for all?**  
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## RECOMMENDATIONS

**Recommendation 1:** That the MSSS commit to participating in a joint working group created by the FNQLHSSC for the purposes of analyzing the impact of the autonomy insurance project on the First Nations of Quebec and formulating recommendations regarding the wording of the bill's parameters or the parameters of any policy stemming from such a bill.

**Recommendation 2:** That the bill slated to build the foundation for autonomy insurance integrate special provisions that allow First Nations to benefit from a distinct plan, and whose mechanisms for implementation be subsequently jointly defined by the AFNQL and the Quebec government .

**Recommendation 3:** That the Minister commit to initiate an impact assessment process that involves prior consultation with the First Nations, and does so as soon as the MSSS begins to elaborate a bill or policy that is likely to have repercussions on the First Nations.



## APPENDIX 1:

### AFNQL RESOLUTION NO. 11/2013



#### Assemblée des Premières Nations du Québec et du Labrador

250, Place Chef Michel Laveau, bureau 201  
Wendake (Québec) G0A 4V0  
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#### RESOLUTION NO 11/2013

#### AUTONOMY FOR ALL: WHITE PAPER ON THE CREATION OF AUTONOMY INSURANCE

- WHEREAS** the Government of Quebec introduced the White Paper on the Creation of Autonomy Insurance, May 30, 2013;
- WHEREAS** this announcement has raised several concerns and questions by the Chiefs' Assembly (AFNQL) and in this regard it has entrusted the FNQLHSSC the mandate to analyze the components of autonomy insurance;
- WHEREAS** the AFNQL Chief requested (August 2013) the full cooperation from Minister Hébert and his staff, and financial support for the creation of an ad hoc working group and the production of a report which includes a status report and recommendations;
- WHEREAS** the FNQLHSSC has begun an analysis process of the White Paper on the Creation of Autonomy Insurance;
- WHEREAS** the Government of Quebec has requested the participation of the AFNQL and FNQLHSSC in special consultations on the White Paper;
- WHEREAS** the FNQLHSSC has continued its analysis and has found that there are missing elements in order to complete this analysis (establishment of the ad hoc working group, historical spending for long-term care, home care by government departments, etc);
- BE IT RESOLVED THAT** the AFNQL and FNQLHSSC are continuing their analysis and, based on these results, they are producing a brief illustrating the need for more information, as well as being involved in the formulation of the draft bill parameters;



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**RESOLUTION NO. 11/2013**

**BE IT RESOLVED THAT** the AFNQL mandates the AFNQL Chief and the FNQLHSSC to present the brief to the National Assembly's Committee on Health and Social Services as part of its special consultations on the "White Paper on the Creation of Autonomy Insurance".

**PROPOSED BY:** Chief Terence McBride, Timiskaming

**APPROVED BY:** Grand Chief Konrad Sioui, Wendake

**ADOPTED BY CONSENSUS ON OCTOBER 23, 2013 IN AKWESASNE**

Ghislain Picard  
Chief of the AFNQL



## **APPENDIX 2:**

# **HIGHLIGHTS FROM THE FIRST NATIONS REGIONAL HEALTH SURVEY (RHS 2008)**

### **Special needs among First Nations children**

- The need or use of additional resources to address special needs was reported for 11.0% of children.
- The most frequently cited special needs of children between the ages of 0 and 11 were: 1) physical and sensory problems as well as cognitive and learning difficulties (4.5%); and 2) problems relating to social, cultural, linguistic or family factors (3.7%).

### **Health problems among First Nations adults**

- Hypertension (29.0%), diabetes (all types, but primarily Type 2) (21.5%), arthritis (17.0%) and allergies (14.0%) topped the list of health conditions most frequently cited by adults.
- With age, First Nations adults are placed at a growing risk of receiving a diagnosis for a chronic disease. Among 35 to 54 year olds, the prevalence of hypertension was 6.3 times higher than among 18 to 34 year olds. Among 55 to 64 year olds, the prevalence rate was 11.0 times higher (45.2 %), and among people aged 65 and old, the prevalence rate was 12.1 times higher.

### **Home care**

- A little under half (46.4%) of adults aged 18 years and over who reported needing home care received it.
- Although the use of home care, and the need for home care, increases with age, 5.1% of people in the 18-54 age group reported needing home care and represented 15.7% of the beneficiaries.
- Two-thirds (66.3%) of adults who received home care were over the age of 65.
- Nearly half (48.2%) of adults aged 75 years and over received home care, compared to 32.0% of adults aged 65-74 and 8.1% of adults aged 55-64.
- The median age of adults upon placement in long-term care facilities outside the community was 68 years.



- Nearly one individual in five (17.4%) aged 18 or over who reported needing home care and who often encountered physical, mental or health challenges which limited the nature of their domestic, professional or other activities did not benefit from home care services.
- Geographic isolation seems to have an influence on service access and usage. In fact, the gap between service needs and usage is significantly wider in hard-to-access communities compared to urban communities.
- More than three-quarters (78.1%) of home care beneficiaries aged 18 years and over reported having two or more chronic health conditions. The most common chronic health conditions reported were hypertension, arthritis and diabetes.
- Chronic diseases and neurological conditions were the two main causes for placement in long-term care facilities outside the community.
- Nearly half (48.5%) of informal caregivers who provided care to loved ones or immediate family members were aged between 35 and 54 and a little over half (56.6%) were women.
- About one in five (19.9%) informal caregivers spent more than 20 hours per week providing home health care, 5.4% of whom spent more than 40 hours per week doing so.
- Half (51.6%) of individuals who provided care or assistance to a friend or family member received support through community services.







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