



**HOUSE OF COMMONS
CANADA**

**THE WAY FORWARD: ADDRESSING THE
ELEVATED RATES OF TUBERCULOSIS
INFECTION IN ON RESERVE FIRST NATIONS AND
INUIT COMMUNITIES**

**Report of the Standing Committee on
Health**

**Joy Smith, MP
Chair**

JUNE 2010

40th PARLIAMENT, 3rd SESSION

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

FOURTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied the Elevated Rates of Tuberculosis Infection in the First Nations and Inuit Communities and has agreed to report the following:

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THE WAY FORWARD: ADDRESSING THE ELEVATED RATES OF TUBERCULOSIS INFECTION IN ON RESERVE FIRST NATIONS AND INUIT COMMUNITIES

INTRODUCTION

On March 11, 2010, the House of Commons Standing Committee on Health passed a motion agreeing to undertake a study to examine the elevated rates of tuberculosis (TB) infection in First Nations and Inuit communities and report its conclusion, including recommendations towards a national strategy to eradicate this disease. The Committee held one meeting examining this topic on April 20, 2010, where they heard from a wide range of witnesses, including: government officials, First Nations and Inuit organizations and communities, public health organizations, and experts in TB prevention and control.

This report provides relevant background regarding tuberculosis in First Nations and Inuit communities, including the federal government's role in this area and highlights the issues raised by witnesses during the course of the hearing. It also provides recommendations for action to be considered by Health Canada in their renewal of the National TB Elimination Strategy for on-reserve First Nations and Inuit communities.

TB IN ABORIGINAL POPULATIONS IN CANADA

A. Incidence of TB in First Nations and Inuit Populations

TB is a serious infectious disease caused by a bacterium, which spreads when someone with the disease coughs and another person breathes the bacteria.¹ TB affects primarily the lungs, but it can also affect other parts of the body such as the lymph nodes.² It is generally thought that once an individual is infected with the TB bacteria he/she remains infected for life.³

1 Health Canada, "First Nations, Inuit and Aboriginal Health: Tuberculosis (TB)" <http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/tuberculos/index-eng.php>

2 Ibid.

3 Health Canada, "Tuberculosis in First Nation Communities," http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/tuberculos/tb_fni-pni_commun-eng.php (accessed April 13, 2010).

Globally, the incidence of TB is 139 cases per 100,000 which translate to close to 10 million cases per year.⁴ In Canada, the incidence of TB is 5 cases per 100,000 people, or an estimated 1,613 new and relapsing cases per year.⁵ However, the majority of these cases occur within two demographic groups: Aboriginal peoples, including First Nations, Inuit and Métis, and individuals born outside of Canada (Table 1). The disproportionate burden of TB among the Aboriginal population is supported by observations that although Canadian-born Aboriginal peoples make up 3.5% of the total Canadian population, they account for 17% of the disease burden.⁶

While the incidence of TB in Aboriginal populations as a whole is higher than in Canadian-born non-Aboriginal populations, there are significant variation rates of TB across regions and between different Aboriginal communities.⁷ For example, in 2004, TB incidence rates in Status Indians ranged from 0 per 100,000 in the Atlantic region to 72.7 per 100,000 in Manitoba. Similarly, Inuit in Quebec reported rates of 95 per 100,000 as compared to 102.2 per 100,000 in the Territories.⁸

4 World Health Organization, "TB," <http://www.who.int/mediacentre/factsheets/fs104/en/index.html>

5 Infection with the TB bacterium often results in asymptomatic, latent disease, which if left untreated will eventually progress to active disease with symptoms.

6 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, "Canadian Tuberculosis Standards, 6th Edition," http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf (accessed April 9, 2010).

7 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, "Canadian Tuberculosis Standards, 6th Edition," http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf, p.300.

8 Atlantic region refers to Newfoundland and Labrador, Nova Scotia, Prince Edward Island and New Brunswick. The Territories include Yukon, Nunavut, and the Northwest Territories.

Table 1 – Tuberculosis in Canada, 2008

Origin Status		Number of Cases	Incidence Rate (per 100,000)
Aboriginal	Indian (status)	218	26.6
	Indian (non-status)	9	-
	Métis	27	8.0
	Inuit	88	157.5
Canadian Born non-Aboriginal		210	0.8
Foreign-Born		987	13.4
Total		1600	4.8

Source: Table prepared by the authors using data obtained from the Public Health Agency of Canada, "Tuberculosis in Canada," <http://www.itk.ca/sites/default/files/Rates%20by%20Origin%202010.pdf> (accessed April 9, 2010).

B. Key Factors affecting TB Prevention and Control in Aboriginal Communities

Since 1991, there has been a global consensus on what constitutes good practice in the prevention and control of tuberculosis, which is reflected in the World Health Organization's Directly Observed Treatment Short-Course (DOTS) Strategy.⁹ On a policy level, the DOTS Strategy requires that there be a political commitment to TB prevention and control, which includes: a declaration of public sector responsibility with a corresponding budget, appropriate management structures, published national guidelines, and sector-wide approaches and policies to ensure that there is sufficient access to health services.¹⁰ From a health care systems perspective, the prevention and control of TB requires: an uninterrupted supply of drugs, diagnosis and follow-up through a quality assured system of bacteriology, a clearly defined monitoring process, and measures to protect against the misuse of medications that could possibly lead to drug resistance.¹¹

9 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, "Canadian Tuberculosis Standards, 6th Edition," http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf, p.239.

10 Ibid.

11 Ibid.

However, despite the existence of this global consensus on best practices, there are many challenges affecting TB prevention and control activities in Aboriginal communities, which can be broadly described as context-, host-, environment-, and system-related issues.¹²

(i) Historical Context

Elevated incidence rates of TB in Aboriginal peoples should be understood within a historical context, where TB infection in Aboriginal communities occurred after contact with Europeans in the 19th and 20th centuries. Since then, rates of TB have been exacerbated by a history of movement of Aboriginal peoples to reserves and residential schools, where crowded living conditions, poverty and malnutrition increased the spread of TB and its progression from infection to disease symptoms.

(ii) Host Related Factors

TB infection rates are affected by the presence of other health-related conditions that are often more prevalent in Aboriginal peoples, such as diabetes mellitus, malnutrition, alcohol and drug use, as well as HIV/AIDS. In addition, there have been documented genetic characteristics, such as congenital immune deficiencies, which increase the susceptibility of certain individuals to TB and prevent the applicability of childhood immunization.

(iii) Environment

TB control efforts are compromised by overcrowded housing and poverty, which are often found on reserves and in remote regions. For example, according to the Canadian Mortgage and Housing Corporation (CMHC), 50% of First Nations housing fell below CMHC standards, and 26% of First Nations and 36% of Inuit reported living in crowded dwellings.¹³

12 Ibid, p.301.

13 Assembly of First Nations – Health and Social Secretariat, “Housing as a social determinant of health increases risks for tuberculosis infection in First Nations and Inuit Peoples,” <http://www.itk.ca/media-centre/media-releases/inuit-tb-rate-doubles-185-times-rate-canadian-born-non-aboriginals-first> (accessed April 13, 2010).

(iv) Health Care System

In remote communities, the capacity for TB control programming, surveillance and diagnosis is also often limited due to understaffing and/or rapid turnover of staff and lack of access to appropriate health services and facilities. There are also unique challenges and needs in providing culturally appropriate programs and care, as well as navigating often complex jurisdictional issues.¹⁴

THE FEDERAL ROLE

A. First Nations and Inuit Health and the *Constitution Act, 1867*

The *Constitution Act, 1867* does not explicitly include “health” as a legislative power assigned either to Parliament (in section 91) or to the provincial legislatures (in section 92). In fact, according to the Supreme Court, “ ‘health’ is not a matter which is subject to specific constitutional assignment, but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in question.”¹⁵ However, the Constitution does contain some powers relating directly to health and health care. Under section 91(11), the federal government is responsible for the “quarantine and the establishment and maintenance of marine hospitals”.¹⁶ Other areas where the federal government is involved in health are derived indirectly from other constitutional powers, including the criminal law power; the spending power; and possibly the power to pass laws for the peace, order and good government of Canada.¹⁷

Meanwhile, the provinces are responsible for most other hospitals under section 92 (7). In addition to their jurisdiction over hospitals, provinces are also responsible for the direct delivery of most health services, the education of physicians, which derives from its powers over property and civil rights under section 92(13)) and matters of a merely local or private nature under section 92(16)) in the *Constitution Act, 1867*.¹⁸

14 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, “Canadian Tuberculosis Standards, 6th Edition,” http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf (accessed April 9, 2010).

15 *Schneider v. The Queen*, [1982] 2 S.C.R. 112 at p. 142.

16 Marlisa Tiedemann, “The Federal Role in Health and Health Care,” 20 October, 2008, Library of Parliament Publication PRB 08-58E, <http://pintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/prb0858-e.pdf>.

17 For a detailed discussion regarding the federal government’s exercise of these constitutional powers in the area of health, please consult the following: Marlisa Tiedemann, “The Federal Role in Health and Health Care,” October 20, 2008, Library of Parliament Publication PRB 08-58E, <http://pintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/prb0858-e.pdf>.

18 Ibid.

While the federal government does not have direct responsibility in the delivery of health care, it does have primary jurisdiction over “Indians and Land reserved for the Indians,” under section 91 (24) of the *Constitution Act, 1967*.¹⁹ In 1939, the Supreme Court decision *Re Eskimos* further brought the Inuit within the meaning of “Indians” under section 91(24).²⁰ However, while section 35 of the *Constitution Act, 1982*, defines Aboriginal peoples as including the “Indian, Inuit and Métis peoples of Canada”²¹, the status of the Métis and the non-registered Indian population²² under section 91(24) remains undetermined.²³ The federal government therefore maintains that it does not have exclusive responsibility for these groups and its financial responsibilities for these groups are thus limited.²⁴ Federal jurisdiction over First Nations and Inuit means that the federal government has the exclusive authority to enact legislation over First Nations and Inuit, which it exercises primarily in relation to on-reserve registered status Indians and, to a lesser extent, the Inuit.²⁵

B. Indian Health Policy 1979

Despite having jurisdiction over First Nations and Inuit, the federal government has not enacted legislation in relation to the provision of health care to First Nations and Inuit²⁶, but rather provides certain health programs and services to on reserve First Nations and Inuit as a matter of policy.²⁷ The 1979 Indian Health Policy outlines the federal role in the provision of health care to First Nations and Inuit, indicating that this policy is based upon

19 Tonina Simeone, “Federal-Provincial Jurisdiction and Aboriginal Peoples” February 1, 2001, Library of Parliament Publication TIPS-88E, <http://pintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95>

20 Ibid.

21 *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, Part II, s.35 (2).

22 Non-Status Indian refers to people who are of Indian ancestry and cultural affiliation, but are not registered as Indians under the *Indian Act* or lost their right to be registered as Indians under the *Indian Act* before it was amended in 1985.²² Tonina Simeone, “Federal-Provincial Jurisdiction and Aboriginal Peoples” February 1, 2001, Library of Parliament Publication TIPS-88E, <http://pintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95>

23 Ibid.

24 Ibid.

25 Registered (Status) Indian: those people who are registered or entitled to be registered as Indians in accordance with the provisions of the *Indian Act*. Tonina Simeone, “Federal-Provincial Jurisdiction and Aboriginal Peoples” February 1, 2001, Library of Parliament Publication TIPS-88E, <http://pintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95>

26 It is important to note that the most significant piece of federal legislation dealing with Indian and lands reserved for them is the *Indian Act*, which governs almost all aspects of the lives and lands of status Indians. The Act “defines who is an Indian and regulates band membership and government, taxation, lands and resources, money management, wills and estates and education.” However, the Inuit are not covered by the *Act*, nor does the *Act* include provisions for the governance and provision of health care. Tonina Simeone, “Federal-Provincial Jurisdiction and Aboriginal Peoples” 1 February, 2001, Library of Parliament Publication TIPS-88E, <http://pintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95>

27 Health Canada, “History of Providing Health Services to First Nations People and Inuit,” <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/services-eng.php>.

“constitutional and statutory provisions, treaties and customary practice.”²⁸ The 1979 Indian Health Policy articulates that due to the integrated nature of the health care system, responsibility for First Nations and Inuit health may be shared between federal, provincial or municipal governments, Indian bands, or the private sector. It identifies the federal role in the interdependent health care system as including: “public health on reserves, health promotion, and the detection and mitigation of hazards to health in the environment.”²⁹ Meanwhile, the provincial and private role includes the diagnosis and treatment of acute and chronic disease and the rehabilitation of the sick. Finally, First Nations and Inuit communities are also identified as having a significant role to play in health promotion and the adaptation of health services delivery to the specific needs of their community.

It is also important to note that this view point differs from that of Aboriginal peoples, who argue the federal government is required to provide health programs and services based upon existing treaty rights and the Crown’s fiduciary responsibility³⁰, rather than as merely a matter of policy.³¹ This view point was articulated in the Royal Commission on Aboriginal Peoples final report in 1996.³²

C. Jurisdictional Disputes in First Nations and Inuit Health: Jordan’s Principle

Disputes between the federal and provincial governments have arisen over First Nations and Inuit health as result of the jurisdictional complexity in the delivery of health care to these population groups. This became evident in the case of Jordan River Anderson, a child from Norway House First Nation who suffered from a rare muscular disorder that required years of medical treatment in a Winnipeg hospital located 800km from his home community. Jordan died in hospital, while the federal and provincial governments negotiated who would pay for the costs for him to return home from the hospital in Winnipeg. In response to his death, the House of Commons unanimously passed Jordan’s Principle in 2007, which stipulates that in the event of a jurisdictional

28 Health Canada, “About Health Canada: Indian Health Policy 1979,” http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php.

29 Ibid.

30 In broad legal terms, a “fiduciary” is “one who holds anything in trust,” or “who holds a position of trust or confidence with respect to someone else.” Hence, a “fiduciary relationship” is one in which someone in a position of trust has “rights and powers which he is bound to exercise for the benefit” of another. Such relationships include those between trustees and their beneficiaries, solicitors and their clients, and so forth. The Crown’s fiduciary relationship to Aboriginal Peoples has not yet been fully defined, but the Supreme Court of Canada has indicated that it includes certain principles and obligations, such as: the Crown must act in the best interests of Indian peoples when dealing with Indian property and lands; and that in dealing with a possible infringement of a constitutionally protected right, the Crown’s first consideration must be to its special trust relationship with Aboriginal peoples. Mary Hurley, “The Crown’s fiduciary relationship with Aboriginal peoples,” August 10, 2001, Library of Parliament Publication PRB 00-09E <http://lpintrabp.parl.gc.ca/lopimages2/PRBpubsArchive/bp1000/prb0009-e.asp>.

31 Commission on the Future of Health Care in Canada, “Building on Values: The Future of Health Care in Canada,” June 2002, http://www.cbc.ca/healthcare/final_report.pdf, p.212.

32 RCAP, “Highlights from the Report of the Royal Commission on Aboriginal Peoples,” <http://www.ainc-inac.gc.ca/ap/pubs/rpt/rpt-eng.asp#toc>.

dispute over funding for a First Nation child, the government of first contact will pay for services and seek cost-sharing later.³³ It is intended to guarantee that the services delivered to Aboriginal children will not be delayed by jurisdictional disputes.³⁴

D. The Federal, Provincial and Territorial Roles in TB Prevention and Control in First Nations and Inuit Communities

In practice, these jurisdictional divisions in First Nations and Inuit health have resulted in the following roles and responsibilities for federal, provincial and territorial governments in addressing TB prevention and control in First Nations and Inuit communities in Canada. Health Canada's First Nations and Inuit Health Branch (FNIHB) has primary responsibility for public health services in on reserve First Nations Communities.³⁵ In addition, according to Health Canada, FNIHB also provides funding for the TB prevention and control program in Nunatsiavut in Labrador.³⁶ Finally, Health Canada also provides a limited range of health-related goods and services, such as drugs, medical transportation, medical supplies and health care equipment through its Non-Insured Health Benefits (NIHB) program.

TB control activities are usually shared between FNIHB and the provinces. Medically necessary health services insured under the *Canada Health Act*³⁷ are the responsibility of provinces for both Aboriginal (both on- or off-reserve and Métis) and non-Aboriginal Canadians.³⁸ Provincial governments receive federal financial support to deliver these insured health services through the Canada Health Transfer.

In order to coordinate these activities between different levels government, many different arrangements exist varying from province to province. In many cases, they have shared and integrated programming and health care delivery for their respective

33 INAC, "Backgrounder-Implementation of Jordan's Principle in Saskatchewan," <http://www.ainc-inac.gc.ca/ai/mr/nr/s-d2009/bk000000451-eng.asp>

34 Ibid.

35 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, "Canadian Tuberculosis Standards, 6th Edition," http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf, p.300.

36 Health Canada, "First Nations, Inuit and Aboriginal Health: TB" <http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/tuberculos/index-eng.php>.

37 Insured hospital services, as defined under the *Canada Health Act*, include medically necessary in-patient and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and X-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

38 Ibid.

populations.³⁹ FNIHB may also support the administration of public health programs by the First Nations and Inuit communities through contribution agreements, or Health Service Transfer Agreements.⁴⁰

In the Northwest Territories, Nunavut and Yukon, centralized TB control programs for First Nations, and Inuit populations are delivered through the respective territorial departments of health. Like in the case of the provinces, the federal government does provide funding to the territories for the provision of medically necessary insured health services through the Canada Health Transfer and the Territorial Financing Formula. However, according to Health Canada officials, FNIHB does not have jurisdiction over the health services of First Nations or Inuit persons who live in Canada's territories.⁴¹

ADDRESSING THE ELEVATED RATES OF TB IN FIRST NATIONS AND INUIT COMMUNITIES

A. Health Canada's National TB Control Program and Elimination Strategy

What the Committee Heard

The Committee heard from department officials that Health Canada is working to reduce TB rates among on-reserve First Nation residents and Inuit through its National TB Control Program.⁴² The overall target of the program is to reduce the number of TB cases among First Nations and Inuit to 3.6 cases per 100,000 population by 2015, a target that has been established for all Canadians and has been adopted from the WHO's Global Stop TB Plan. Health Canada's National TB Control Program aims to achieve this target by ensuring equitable access to timely diagnostics, treatment and follow-up care for those exposed to and diagnosed with TB. TB prevention and education are also important components of the program.

The Committee learned that Health Canada implements its National TB Control Program through the regional offices of its First Nations and Inuit Health Branch, who in turn establish partnerships with provincial governments, local or regional health authorities and First Nations communities to deliver TB prevention and control services.⁴³ FNIHB's regional offices work with these key partners to ensure that the Canadian TB Standards,

39 Ibid.

40 Ibid.

41 House of Commons Standing Committee on Health, "Evidence," 20 April, 2010, Number 010, 3rd Session of the 40th Parliament, <http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4443113/HESAEV10-E.PDF>, p.2

42 Ibid, p.1

43 Ibid, p.2

which provide the Canadian standard for both public health and clinical management aspects of TB prevention and control, are applied in on reserve First Nations and Inuit communities.

Health Canada officials further articulated that this program was being funded by the Government of Canada at a rate of \$6.6 million per year and between 2004 and 2010, \$42.4 million had been allocated to the program.⁴⁴ In addition, the federal government had provided an additional \$3 million to address TB outbreaks in communities in Manitoba and Saskatchewan.⁴⁵

Finally, department officials indicated that it was currently renewing the National TB Elimination Strategy through a working group of federal partners, external TB experts, stakeholders and First Nations and Inuit partners. The strategy is considered to be a component of an overarching national TB strategy currently being developed by the Public Health Agency of Canada (PHAC).⁴⁶

Despite these efforts, the Committee heard from some witnesses that there is a need to improve the quality of FNIHB's National TB Control Program.⁴⁷ First, according to some witnesses, there is a lack of consistency in the program from region to region. In particular, common national and international standards in TB prevention and control are not being applied in all regions. For example, some witnesses articulated that there is no consistency in how different regions define a TB outbreak. Second, some witnesses felt that FNIHB's regional branches were not held accountable in their TB prevention and control efforts. Unlike their provincial and territorial counterparts, FNIHB's regional branches are not required to meet annual targets in reduction rates for TB infections, or report on their progress.⁴⁸

Third, witnesses indicated that insufficient resources were being provided to support TB prevention and control efforts in First Nations and Inuit communities. They pointed to a report commissioned by PHAC, which indicated that FNIHB invests only \$16,700 per case in treating First Nations citizens, while, on average, Canada invests \$47,000 in each case of TB for among the non-native population.⁴⁹ Other witnesses said that remote communities lacked the technology necessary for TB diagnosis, such as mobile chest X-ray units. Witnesses also emphasized the need for long term sustained funding and resources for TB due to the nature of the disease itself, which takes six months or more to

44 Ibid.

45 Ibid, p.10

46 Ibid, p.2

47 Ibid, p.3

48 Ibid.

49 Ibid.

be cured and can remain latent within a community over the course of generations without treatment.⁵⁰ Witnesses pointed out that it took 30 years to reduce TB rates in the general population to their current levels of below one case per 100,000 population.⁵¹

Finally, Gail Turner from Inuit Tapiriit Kanatami articulated that Health Canada's current policies and programs are insufficient to address the unique challenges of TB prevention and control in remote and northern Inuit communities.⁵² According to Ms. Turner, Inuit communities require a separate TB control and prevention strategy to address the excessively high rates of TB among the Inuit, which have reached 500 per 100,000 in some communities.⁵³ A separate strategy is needed because of their unique geographic and social concerns, including a lack of access to health care in their northern remote communities, higher levels of overcrowding housing, and a greater degree of food insecurity than in other communities.

What the Committee Wants

The Committee is deeply concerned that TB rates among the Aboriginal population, and in particular First Nations and Inuit people, remain disproportionately high when compared to the overall Canadian population. According to testimony, TB rates among members of First Nations were 31 times higher than among others born in Canada in 2008.⁵⁴ The numbers are starker when looking at the Inuit Nunaat⁵⁵, who experience rates that are 185 times higher than those of Canadian-born non-Aboriginals.⁵⁶ In addition, the Committee is worried about the First Nations and Inuit communities that are at the epicentre of the TB outbreaks. For these reasons, the Committee believes that the renewal of the National TB Elimination Strategy needs to be accelerated to address this urgent and ongoing problem. In addition, the Committee believes that the concerns raised by witnesses regarding the efficacy of Health Canada's National TB Control Program also need to be addressed. The Committee therefore recommends:

- **That Health Canada accelerate the renewal of its National TB Elimination Strategy utilized in on reserve First Nations and Inuit communities.**

50 Ibid, p.12.

51 Ibid.

52 Ibid, p.4.

53 Ibid, p.12.

54 Ibid, p.2.

55 The majority of Inuit live in one of four regions known collectively as Inuit Nunaat, the Inuktitut expression for "Inuit homeland". It comprises Nunavut, Nunavik (in northern Quebec), Nunatsiavut (in Labrador) and Inuvialuit (in the Northwest Territories). Inuit comprise roughly 85% of the population of the territory of Nunavut and also represent the majority populations in Nunavik and Nunatsiavut.

56 Ibid, p.3.

- That Health Canada define a TB Control Program for on reserve First Nations and Inuit communities, with goals and targets, and performance indicators that are measured annually at the regional and/or national level in order to determine whether its regional branches are delivering the program according to national and international standards in TB prevention and control.
- In recognition of the federal government’s fiduciary responsibility towards Aboriginal peoples and its other related responsibilities, that Health Canada take a long-term and collaborative approach to this issue with sufficient funding to sustain a long-term program.
- That the Auditor General evaluate the impact of past allocations to Health Canada’s National TB Control Program.
- That the Government of Canada establish an emergency fund to support communities at the epicentre of the TB outbreaks. This fund could be used to support the activities of emergency assessment teams, if they are specifically requested for by the provinces and territories.

B. Collaboration Across Jurisdictions

What the Committee Heard

The Committee also heard from witnesses that TB prevention and control in First Nations and Inuit communities was confounded by a lack of collaboration across jurisdictions. Witnesses explained that the division of responsibilities between the federal and provincial governments in this area had resulted in a fragmented system. For example, in Manitoba, TB prevention and control activities are conducted by numerous different agencies within the province, where some are accountable to the province and others are accountable to FNHI through contract arrangements.⁵⁷ As a result, overall responsibility and accountability for the reduction of TB rates in First Nations communities remained “opaque.”⁵⁸ Jurisdictional divisions also meant that the data required to support TB prevention and control programming was not easily shared between provincial governments and FNHI.⁵⁹ Witnesses articulated that successful collaboration between

57 Ibid, p.15 and p.18.

58 Ibid, p.2.

59 Ibid, p.12 and p.19.

different levels of government in TB prevention and control programming had only been achieved in some provinces due to the force of the personalities of those running the various programs.

According to Inuit Tapiriit Kanatami, there is equally a lack of clarity of who is responsible for the Inuit.⁶⁰ While Inuit communities are engaged with FNIHB in TB prevention and control, they are not engaged with the provinces, which also have responsibility for their public health. As a result, they are uncertain as to who is responsible for ensuring that they have the medical equipment necessary to diagnose and treat TB.

This lack of collaboration across jurisdictions led witnesses to call for a single unified TB prevention and control program to replace the current system of a mix of provincial and federal TB programs. Some argued that a singular TB prevention and control program for both Aboriginal and non-Aboriginal Canadians should be developed under the responsibility of the chief provincial officer of health.⁶¹ Others called for a pan-Canadian TB program, where national standards, goals and targets would be established at the federal level to assure uniformity, but the program would be administered provincially.⁶² Finally, some witnesses suggested that F/T/P governments work together to delineate jurisdictional responsibilities in TB prevention and control and develop mechanisms that hold all levels of government and agencies to account in reaching common goals in reduction in the number of TB cases in these population groups.⁶³

What the Committee Wants

The Committee recognizes the challenges associated with TB prevention and control that arise as a result of shared jurisdiction in delivering health care to First Nations and Inuit peoples. The Committee further acknowledges the importance of respecting federal, provincial and territorial jurisdictions in this area. However, the Committee believes that greater effort is needed to promote collaboration and accountability among and between jurisdictions in addressing TB in First Nations and Inuit communities. The Committee therefore recommends:

- **That federal, provincial and territorial governments establish clear lines of responsibility for medical TB treatment for all Aboriginal peoples.**

60 Ibid, p.9

61 Ibid. p.12

62 Ibid, p.16

63 Lung Association of Saskatchewan, Letter Submitted to the House of Commons Standing Committee on Health, April 23, 2010.

- That all levels of government, inter-tribal health authorities, Métis and Inuit organizations and First Nations collaborate closely in order to remove jurisdictional constraints in providing optimal TB care to First Nations, Inuit and Métis people.
- That Jordan’s Principle be adopted and applied in the context of TB prevention and treatment to ensure that the necessary care for a First Nation’s child is not delayed or disrupted due to jurisdictional disagreement or dispute.
- That data be collected by federal, provincial and territorial levels of government in a manner that preserves personal privacy and confidentiality, while otherwise being available across jurisdictions to track TB cases when necessary.

C. Involvement of First Nations and Inuit Communities in TB Prevention and Control

What the Committee Heard

Witnesses appearing before the Committee highlighted the importance of the involvement of First Nations and Inuit communities in TB prevention and control programming. The Committee heard that active participation of First Nations and Inuit communities in decision making and the administration of TB programs are necessary in order to promote community ownership, as well as develop local capacity in addressing TB.⁶⁴ The Committee learned about a successful initiative in British Columbia called Strategic Community Risk Assessment and Program for TB (SCRAP-TB).⁶⁵ Funded by the federal government and other partners, SCRAP-TB is a grass-roots initiative that enables the participation of First Nations communities in the process of addressing TB, including raising awareness and participation in the direct observation of the TB therapy programs. According to witnesses, SCRAP-TB demonstrates the need to develop TB programs that reflect the different needs and cultures of First Nations and Inuit peoples, rather than pursuing a “one size fits all” approach.⁶⁶

64 Ibid, p.12.

65 Ibid, p.18.

66 Ibid.

What the Committee Wants

The Committee believes that the engagement of First Nations and Inuit communities as full partners is necessary to address the elevated rates of TB in these communities. The Committee supports the Government of Canada's ongoing efforts to work with these communities to engage leaders and develop local capacity in addressing this problem. The Committee further recognizes that TB prevention and control programming must reflect the diverse needs and cultures of Canada's Aboriginal populations. The Committee therefore recommends:

- **That Health Canada continue to engage First Nations and Inuit communities as full partners in the development of TB programs and strategies.**
- **That Health Canada's TB programming and national strategy focus on enhancing local capacity to promote community ownership of problems and solutions.**
- **That Health Canada support grass-roots programs, such as SCRAP-TB, that build capacity for community-led programs, as part of its overall strategy to address TB in these communities.**

D. Social Determinants of Health

What the Committee Heard

All witnesses appearing before the Committee emphasized that it was also necessary to address the social and economic conditions that facilitate the spread of TB in First Nations and Inuit communities. For witnesses, TB is "a social disease with a medical aspect."⁶⁷ In particular, witnesses linked poor housing conditions to the spread of TB in First Nations and Inuit communities. The Committee heard that houses in Northlands First Nation in Lac Brochet, Manitoba had an average of 5.2 persons living in them, and most lacked proper ventilations systems.⁶⁸ Overcrowded houses with poor ventilation systems increase the risk of TB transmission, because it increases the likelihood that more people will be exposed to and inhale TB bacteria, while living together in a small space.⁶⁹

67 Ibid, p.14.

68 Ibid, p.4.

69 Assembly of First Nations, "Fact Sheet: Housing as a Social Determinant of Health Increases Risks for Tuberculosis Infection in First Nations and Inuit Peoples," 2010, submitted to the House of Commons Standing Committee on Health.

Furthermore, a lack of food security, including access to nutritious foods such as fruits and vegetables, means that First Nations and Inuit peoples have weaker immune systems, which could result in a greater likelihood of TB progressing from infection to disease.⁷⁰

The Committee also heard from witnesses that current efforts to address the social determinants of health by the federal government were unsatisfactory. Witnesses said that there was a lack of coordination between Health Canada and Indian and Northern Affairs Canada (INAC) in addressing issues such as food security and housing.⁷¹ In addition, existing programs to address food security did not take into account local conditions. For example, the INAC's food mail program that subsidizes the cost of food purchased by Northerners requires that food be purchased by credit cards, which few Inuit have.⁷² Finally, representatives from First Nations communities articulated that the Government of Canada had an obligation to address the social determinants of health as an issue of justice in line with Article 25 (1) of the Universal Declaration of Human Rights, which states that⁷³:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

What the Committee Wants

The Committee recognizes the importance of addressing TB in First Nations and Inuit communities in the context of the wider social determinants of health. Action on the social determinants of health will serve to complement public health efforts in preventing the spread of TB. The Committee believes that a whole-of-government approach is necessary to address the social determinants of health and greater coordination between federal departments with responsibilities related to First Nations and Inuit peoples is therefore also necessary. Consequently, the Committee recommends:

- **That the Government of Canada addresses the social determinants of health as part of its overall strategy to reduce the rates of tuberculosis in on reserve First Nations and Inuit communities.**

70 House of Commons Standing Committee on Health, *Evidence*, April 20, 2010, No. 10, 3rd Session of the 40th Parliament, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4443113/HESA_EV10-E.PDF, p.14.

71 *Ibid*, p.4.

72 *Ibid*, p.13.

73 *Ibid*, p.5.

- **That the Government of Canada establishes an interdepartmental committee to promote horizontal collaboration on the social determinants of health among federal departments with responsibilities related to First Nations and Inuit.**

THE WAY FORWARD

The Committee believes that the elevated rates of TB in First Nations and Inuit communities is an urgent problem that needs to be addressed through effective collaboration between all levels of government and First Nations and Inuit communities themselves. The Committee further believes that the Government of Canada has a leadership role to play in promoting this collaboration through its ongoing efforts to improve its existing national strategy to eliminate TB in on reserve First Nations and Inuit communities. The purpose of the Committee's study is to provide guidance to the Government of Canada in its current efforts to renew its National TB Elimination Strategy for on reserve First Nations and Inuit communities. The study revealed four main areas of action that should be addressed as components of this strategy, including:

- 1) Improve existing TB strategies and programs by developing national goals, targets and performance indicators measured on an annual basis to hold all players to account in their efforts to address this problem.
- 2) Address jurisdictional challenges in providing seamless TB prevention and treatment programs to First Nations and Inuit communities.
- 3) Ensure the involvement of First Nations and Inuit communities in the development of TB strategies and programming to promote equality, community ownership and capacity building.
- 4) Include measures to address the social determinants of health as a key component of a TB elimination strategy for on reserve First Nations and Inuit communities.

The Committee believes that taking action in these areas is the way forward in reducing the disparities in health between First Nations and Inuit and non-Aboriginal Canadians, as manifested by the disproportionately high rates of TB in on reserve First Nations and Inuit communities across the country.

LIST OF RECOMMENDATIONS

A. Health Canada's National TB Control Program and Elimination Strategy

- **That Health Canada accelerate the renewal of its National TB Elimination Strategy utilized in on reserve First Nations and Inuit communities.**
- **That Health Canada define a TB Control Program for on reserve First Nations and Inuit communities, with goals and targets, and performance indicators that are measured on an annual basis at the regional level and/or national level in order to determine whether its regional branches are delivering the program according to national and international standards in TB prevention and control.**
- **In recognition of the federal government's fiduciary responsibility towards Aboriginal peoples and other related responsibilities, that Health Canada takes a long-term and collaborative approach to this issue with sufficient funding to sustain a long-term program.**
- **That the Auditor General evaluates the impact of past allocations to Health Canada's National TB Control Program in on reserve First Nations and Inuit communities.**
- **That the Government of Canada establish an emergency fund to support communities at the epicentre of the TB outbreaks. This fund could be used to support the activities of emergency TB assessment teams if they are specifically requested for by the province or territory.**

B. Collaboration Across Jurisdictions

- **That federal, provincial and territorial governments establish clear lines of responsibility for medical TB treatment for all Aboriginal peoples.**

- That all levels of government, inter-tribal health authorities, Métis and Inuit organizations and First Nations collaborate closely in order to remove jurisdictional constraints in providing optimal TB care to First Nations, Inuit and Métis people.
- That Jordan's Principle be adopted and applied in the context of tuberculosis prevention and treatment to ensure that the necessary care for a First Nation's child is not delayed or disrupted due to jurisdictional disagreement or dispute. (Canadian Public Health Association)
- That data be collected by federal, provincial and territorial levels of government in a manner that preserves personal privacy and confidentiality, while being otherwise available across jurisdictions in order to track TB cases when necessary.

C. Involvement of First Nations and Inuit Communities in TB Prevention and Control

- That Health Canada continue to engage First Nations and Inuit communities as full partners in the development of TB programs and strategies.
- That Health Canada's TB programming and national strategy focus on enhancing local capacity to promote community ownership of problems and solutions.
- That Health Canada support grass-roots programs, such as SCRAP-TB, that build capacity for community-led programs, as part of its overall strategy to address TB in these communities.

D. Social Determinants of Health

- That the Government of Canada addresses the social determinants of health as part of its overall strategy to reduce the rates of tuberculosis in on reserve First Nations and Inuit communities.

- That the Government of Canada establishes an interdepartmental committee to promote horizontal collaboration on the social determinants of health among federal departments with responsibilities related to First Nations and Inuit.

APPENDIX A LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
As Individuals	2010/04/20	10
Earl Hershfield, Professor of Medicine, University of Manitoba, Former Director of Tuberculosis, Province of Manitoba		
Pamela Orr, Professor, Department of Medicine, Medical Microbiology and Community Health Science, University of Manitoba		
Assembly of First Nations		
Chief Angus Toulouse, Regional Chief		
Kiimberley Barker, Public Health Advisor		
Canadian Lung Association		
Brian Graham, Chair of the Chronic Disease Policy, Chief Executive Officer of the Lung Association of Saskatchewan		
Canadian Public Health Association		
Elaine Randall, Communicable Disease Consultant, Department of Health and Social Services, Government of Nunavut		
James Chauvin, Policy Director		
Canadian Society for International Health		
Janet Hatcher Roberts, Executive Director		
Department of Health		
Shelagh Jane Woods, Director General, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch		
Rose-Marie Ramsingh, Executive Director, Community Medicine, First Nations and Inuit Health Branch		
Inuit Tapiriit Kanatami		
Elizabeth Ford, Director, Department of Health and Environment		
Gail Turner, Chair, National Committee on Health and Director of Health Services, Department of Health and Social Development, Government of Nunatsiavut		
Northlands Denesuline First Nation		
Chief Joseph Dantouze		
University of Alberta		
Richard Long, Professor, Director of the Tuberculosis Program Evaluation and Research Unit, First Nations and Inuit Health Immediate Past Medical Officer of Health for Tuberculosis, Province of Alberta		
Anne Fanning, Professor Emeritus, Faculty of Medicine		

APPENDIX B LIST OF BRIEFS

Organizations and Individuals

Assembly of First Nations

Canadian Lung Association

Canadian Society for International Health

Inuit Tapiriit Kanatami

University of Alberta

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings ([Meetings Nos. 10 and 18](#)) is tabled.

Respectfully submitted,

Joy Smith, MP

Chair

Liberal Report to ‘The Way Forward: Addressing the Elevated Rates of Tuberculosis Infection in First Nations and Inuit Communities’

From H1N1, to the isotopes shortage, and as we have seen now with the elevated rates of tuberculosis infection in First Nations and Inuit Communities, the Conservative Government’s response to health issues is to wrap itself in a constitutional cocoon refusing to acknowledge its responsibility and authority for the health of Canadians.

This government’s failure to accept any responsibility for the health of Canadians is nothing new. In June 2008 we wrote a dissenting report for the *Statutory Parliamentary Review of the 10-year plan to Strengthen Health Care*. We noted, “This Conservative government has taken a rigid stance on health care being a provincial responsibility and has therefore refused to participate. The responsibility for the health of Canadians is clearly a shared responsibility across all government departments, across all jurisdictions and across all sectors. There is no partner in Ottawa for Health and Health Care.” These same words could be written today.

Every health-related question we ask this government is met with a familiar refrain: “we’re working with the provinces and territories”; “the delivery of health care is a provincial and territorial responsibility”; “this is the jurisdiction of the provinces and territories”.

If this government were truly working with the provinces and territories, the stakeholders on the ground, and listening to the excellent testimony by the myriad of expert witnesses with years of experience combating tuberculosis, they would hear the pleas for federal leadership. They would also hear that when the federal government does play a role, that it must be one of facilitation and solutions rather than obstruction.

All substantial material presented at the Standing Committee on Health hearing on April 20, if acted upon, would assist in significantly improving prevention and treatment of tuberculosis (TB) in First Nation and Inuit communities in Canada.

Our goal of this report – in the absence of any leadership from the Conservative government – is to ensure that the elevated TB rates are recognized as an urgent problem requiring urgent action (as the rates are, in some cases, comparable to a century ago, and to some Sub-Saharan African rates today), that Inuit and Métis are included in the tuberculosis strategy, and that jurisdictional challenges be clarified so that responsibility is not deflected, and people do not ‘fall through the cracks’ of the system, and ultimately suffer.

Over the last five years, \$42 million was spent on TB programs, yet the rates of infection continued to climb. Going forward, we want to insure that funds are used in the best manner possible - allocated to regions, with real targets, with real accountability.

As we saw with the H1N1 crisis, the 4 C’s of David Naylor’s Report written in the aftermath of SARS – communication, collaboration, cooperation, and a clarity of who does what when – were not adhered to while addressing the issue of tuberculosis infection in First Nations and Inuit Communities.

Jurisdictional disputes are simply inexcusable when they impact a disease as devastating and potentially deadly as tuberculosis - a disease for which Canada has pledged to meet international standards.

Canada has a duty and moral responsibility to work with Aboriginal Canadians to reduce the incidence of TB, particularly when First Nations (with an incidence rate of 26.6 per 100,000) and Inuit (157.5 per 100,000) have a significantly higher rate of a disease than Canadian born non-Aboriginal (0.8 per 100,000).

An example of this dysfunction was evidenced by the testimony of Dr. Earl Hershfield, who stated that Manitoba's regional branch of FNIHB, "abdicated their responsibility by contracting out the services on reserve to the Winnipeg Regional Health Authority. The Winnipeg Regional Health Authority, in my view, looks after health in Winnipeg. I have no idea what it's doing on reserve." He further stated, "there isn't a regular TB program directed from the top down. That is one of the problems in Manitoba and it is why, as I see it, Manitoba has the highest TB rates in Canada outside of Nunavut."

Tuberculosis control is simple and is based on the global standard to find new cases, cure these cases, find infections and prevent progression to active disease and maintain surveillance in high risk groups. The Minister of Health must take responsibility in ensuring a collaborative response is executed among jurisdictions. To ensure collaboration across jurisdictions, we recommend:

- The federal Minister of Health call for an emergency meeting of provincial and territorial ministers of health, as well as leaders of national Aboriginal organizations, to take an honest look at issues of jurisdiction and process that may be behind the current rates of TB in Canadian Aboriginal peoples
- That Provincial and Territorial ministers of Aboriginal affairs, as well as Indian and Northern Affairs Canada, convene a First Ministers' Meeting to address the social determinants of health
- That Federal, Provincial, and Territorial governments include Métis in programs and strategies that address TB in Aboriginal communities
- That one single unified TB program in each province and territory be established for both Aboriginal and non-Aboriginal peoples. The program must be accountable to, and the responsibility of, the Chief Provincial or Territorial Medical Officer of Health (CPMOH), and must be evaluated annually, based on agreed deliverables for which the provinces must be accountable

We believe that the Public Health Network put in place in the aftermath of SARS must be formalized, and be tasked to lead any subsequent public health outbreak. This Public Health network would be run out of the Public Health Agency of Canada, and fall under the leadership of the Chief Public Health Officer for Canada. This new network would be tasked with:

- Revising and renewing the First Nations National TB Elimination Strategy. It is unacceptable that the Canadian Tuberculosis Prevention and Control Strategy - drafted in Winter, 2009 - shows in appendix 9 that the FNIHB TB strategy remains under construction
- Urgently defining a TB control program and strategy – the what, by when, and how - with goals and performance indicators that are measured at the provincial, territorial and regional level in order to determine whether regional branches are delivering the program according to national and international standards in TB prevention and control. Performance must be evaluated on an annual basis.
- Initiating an emergency strategy to immediately send in teams to the epicentre of the TB outbreaks to provide assessments to start addressing the problem

- Engaging First Nations and Inuit communities as full partners in the development of TB programs and strategies
- Ensuring that there are clearly articulated objectives and performance targets, and an evaluation process. These must be based on the agreed upon deliverables and must meet national and international standards. The data from each of the provincial/territorial evaluations must be openly available and shared with all concerned groups (government/nongovernment/academic/clinicians and aboriginal communities and organizations) and be the basis on which changes are made to improve outcomes. A national consensus conference should be convened to define the program goals and performance indicators
- Ensuring that the \$47,000 needed to treat each case of tuberculosis – as suggested by the Canadian Tuberculosis Prevention Control Strategy Winter 2009 draft document – is readily available
- Starting TB programs that support, nurture and form a true partnership with those in each community or social group to improve, enhance and build “capacity”, in order to promote community ownership of problems and the solutions. Building capacity in partnership with communities will require an investment in training of community health aides, and should reinstitute a cadre of health workers who are well trained, respected, rewarded and sustained.
- Addressing the social determinants of health as part of its overall strategy to reduce the rates of tuberculosis in First Nations and Inuit communities, including poverty, overcrowding, poor housing, poor nutrition, HIV/ AIDS and Diabetes Mellitus amongst others. Ignoring the disparity in social determinants is no longer an option, but delays in improvement cannot be an excuse for failing to deliver strong sustained, measurable TB control programs now

Finally, we would like to address an issue that was not discussed at the Standing Committee: the co-epidemic of HIV/AIDS and TB. Although incidence of HIV has decreased in the Canadian population, HIV rates have steadily increased in First Nations and Inuit populations.

Although Aboriginal people represent only 3.3% of the Canadian population, they have 5-8% of prevalent infections and 6-12% of new HIV infections in Canada in 2002.

People with HIV are up to 50 times more likely to develop TB than HIV-negative people. This is because (1) HIV affects the immune system and increases the likelihood of people acquiring new TB infection; and (2) also promotes the progression of latent TB infection to active disease and relapse of the disease in previously treated patients.

We believe that diagnosis and treatment of HIV/AIDS is a must, as is diagnosis and treatment of TB.

To conclude, we believe that the elevated rates of TB in First Nations and Inuit communities is an urgent problem that needs to be addressed through communication, collaboration, cooperation, with a clarity of who does what and when between all levels of government and First Nations and Inuit Communities themselves. The federal government must stop abdicating its responsibility and play a leadership role in promoting this collaboration through the development of a national strategy to eliminate TB in First Nations and Inuit Communities. Federal leadership cannot be obstruction. These matters are of such urgency that they demand immediate corrective action, and the attention of an interdepartmental committee at the federal level. Formalizing the Public Health Network is a necessary start to this strategy.

**Bloc Québécois – Supplementary Opinion
Report of the Standing Committee on Health**

***The Way Forward: Addressing the Elevated Rates of Tuberculosis Infection in
On-reserve First Nations and Inuit Communities***

First of all, the Bloc Québécois would like to acknowledge the valuable contribution of the stakeholders and witnesses who participated in this study of elevated rates of tuberculosis infection in Aboriginal communities. The Bloc Québécois supports the spirit of this committee report which advocates action to address these high rates of infection. Committee members should also be congratulated for highlighting the importance of enlisting Aboriginal communities in the fight against tuberculosis and for proposing that Jordan's Principle be applied. However, the Bloc Québécois would like to raise two important points that require comment.

RESPECTING QUEBEC'S ESTABLISHED ORGANIZATIONS

The report states that the federal government has some responsibility regarding the health of the Inuit, including those living in Nunavik. However, Quebec's regional health and social services boards are well-established organizations, and the Nunavik board directs health initiatives in that region. It is essential for the federal government to respect the board's long-standing jurisdiction in Nunavik and the policies of the Quebec Ministry of Health and Social Services. The Inuit of Nunavik have their own regional board and are responsible for administering the services provided for by the *Act respecting health services and social services*, as set out in the James Bay Agreement.

SPENDING POWER

In the section entitled "The Federal Role," the report also mentions the federal government's so-called "spending power." Successive Quebec governments have challenged this view of federalism, and the Bloc Québécois cannot let this reference to federal power go unmentioned. The report states that this constitutional power allows the federal government to be involved in the area of health. However, Quebec has always maintained that this "spending power" simply does not exist and that federal interventions in areas under Quebec jurisdiction are unconstitutional. In short, the Bloc Québécois cannot ignore the groundless claim contained in the report.

