Health Reform Monitor

Advancing Indigenous primary health care policy in Alberta, Canada

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A B S T R A C T

For Indigenous people worldwide, accessing Primary Health Care (PHC) services responsive to socio-cultural realities is challenging, with institutional inequities in healthcare and jurisdictional barriers encumbering patients, providers, and decision-makers. In the Canadian province of Alberta, appropriate Indigenous health promotion, disease prevention, and primary care health services are needed, though policy reform is hindered by complex networks and competing interests between: federal/provincial funders; reserve/urban contexts; medical/allied health professional priorities; and three Treaty territories each structuring fiduciary responsibilities of the Canadian government. In 2015, the Truth and Reconciliation Commission (TRC) of Canada released a final report from over six years spent considering impacts of the country’s history of Indian residential schools, which for more than a century forcibly removed thousands of children from their families and communities. The TRC directed 94 calls to action to all levels of society, including health systems, to address an historical legacy of cultural assimilationism against Indigenous peoples. To address TRC calls that Indigenous health disparities be recognized as resulting from previous government policies, and to integrate Indigenous leadership and perspectives into health systems, PHC decision-makers, practitioners, and scholars in the province of Alberta brought together stakeholders from across Canada. The gathering detailed here explored Indigenous PHC models from other Canadian provinces to collaboratively build relationships for policy reform and identify opportunities for PHC innovations within Alberta.

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1. Introduction: Indigenous primary health care reform in Canada

Since the 1980s, primary health care (PHC) reform in Canada has been an organizing force for health system improvement, shifting services towards inter-disciplinary team-based models of care. Canada is behind other Commonwealth countries like Australia, which first introduced PHC reforms in the early 1970s, examples there being Primary Health Networks and Aboriginal Community-Controlled Health Services (ACCHS) [1]. Canada’s early reforms focused on small-scale pilots transforming delivery and organization of community-based health promotion, disease and injury prevention, and chronic disease management. The Primary Health Care Transition Fund (PHCTF) in the early 2000s was the largest allocation supporting PHC reform in Canada – an $800 million CAD investment over six years in upstream efforts connecting PHC to community supports addressing social determinants of health [2,3]. Activities were organized around five funding ‘envelopes’ (i.e., provincial, national, multi-jurisdictional, official language minority, and Indigenous/Aboriginal initiatives). This last envelope reflects that Indigenous populations (i.e., First Nations, Métis, and Inuit peoples all descended from original inhabitants of the country), which compose 4.3% of Canada’s population [5], are among the most medically underserved.

Canada has not been alone in this shift towards Indigenous community control over primary health care services, making

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community-oriented policy reform the international standard. For instance, Australia too has made strides in Indigenous leadership and inclusion in the delivery of community-based health services. The ACCHSs are authorities on PHC and do much more than deliver clinical services alone; first established in 1971, they connect with Indigenous community members, strengthen community resilience, and provide culturally appropriate comprehensive care [1]. In parallel, Canada’s Health Transfer Policy (HTP) promotes community uptake of services funded by Health Canada’s First Nations and Inuit Health Branch (FNIBH) [7]. In recent decades, new challenges have emerged around how innovations since the 1980s are best scaled, as the magnitude of needed transformation is immense and broader learning from pockets of innovation encumbered by geographic, structural, social, and cultural diversity across Indigenous contexts.

Additional funding for Indigenous-focused PHC reform came by way of a $200 million CAD Aboriginal Health Transition Fund (AHTF, 2004–2010), the result of government and national Indigenous leader meetings to address health disparities [4]. Though not PHC-specific, the AHTF became another policy foundation supporting transformation of PHC services for Indigenous peoples. Activities developed or strengthened PHC centres, including enhancing health teams for improved support of people with unique needs, such as in mental health. This generated further impetus for innovating HTP arrangements, which since 1989 have led to as much as 85% of eligible First Nation and Inuit communities and tribal councils in Canada assuming some degree of responsibility for planning and delivery of community-based health services [6]. Beyond broad PHCTF aims to enhance coordination across health organizations, accountability to stakeholders, quality of services, and linkages between PHC and social services [8], contextual considerations have long complicated Indigenous-focused initiatives. The challenge remains to generalize lessons learned from such work, to identify foundational principles and processes around Indigenous-focused PHC as means of effectively scaling and evaluating innovations. The question addressed here is not simply to identify what policy or model of care may be implemented in a given context, but to develop best practices for moving beyond the contextual specificity of local projects towards integrated initiatives with measurable impacts across Indigenous health systems, with sound evidence to guide future reforms.

2. PHC reform as key to reconciliation

Since 2015, the Truth and Reconciliation Commission of Canada’s (TRC) final report and 94 calls to action [9] have directed all levels of government, including healthcare systems, to re-orient services for Indigenous populations. The Commission detailed how more than a century of the Indian Residential Schools system, by which more than 150,000 First Nations, Métis and Inuit children were forcibly removed from their communities, operated on a federal policy for cultural assimilation. The health legacy persists today in a disproportionate disease burden among Indigenous populations [10–12], evident in health care experiences characterized by ongoing discrimination and unequal treatment [13]. Indigenous people’s health is typically reported through a deficit lens [14], overlooking local wisdom, resilience, and creativity to lead solutions within communities.

As indicated, Indigenous-driven models for meeting community health care needs have tended to be mobilized in pilot efforts isolated from wider systemic transformations. Notable exceptions include innovations in the provinces of Ontario and British Columbia, where system-level initiatives have sought to fill gaps experienced, for instance, when patients move between jurisdictions, such as from on-reserve services historically admin-

istered federally through Health Canada and urban services in the domain of provincial providers. Ontario’s ten Aboriginal Health Access Centres (AHACs) provide services in on- and off-reserve, urban, and rural/northern locations, focusing on integrated chronic disease prevention and management, family-focused care, youth empowerment programming, addictions counselling, and the incorporation of traditional healing (https://www.aohc.org/aboriginal-health-access-centres). Meanwhile, British Columbia’s First Nations Health Authority (FNHA) took over services previously provided by Health Canada’s FNIBH, securing Indigenous control and management of health promotion and disease prevention across regions (http://www.fnha.ca/about/fnha-overview). Achieved in the 1990s and 2013, respectively, both models predate the TRC, though they move their systems towards establishing measurable goals for closing health outcomes gaps (TRC call 19), addressing jurisdictional disputes for people who do not reside on reserves (TRC call 20), integrating Indigenous approaches to healing (TRC calls 21 & 22), and ensuring the recruitment and retention of Indigenous health professionals (TRC call 23).

In Alberta, integration of PHC for Indigenous persons has long been incomplete, rendering pockets of promising innovation vulnerable to political currents. This is not due to health service funding structures alone, but also inconsistent political will to enable cross-sector collaboration towards sustainable solutions [15,16]. In January 2016, energized by the TRC’s calls to action, Indigenous service providers convened in Alberta with provincial health system leaders, PHC practitioners, and scholars to explore possibilities for innovating Indigenous PHC in the province. Objectives for the gathering held on the Tsuut’ina First Nation adjacent to the city of Calgary, were to share and explore opportunities to innovate Indigenous PHC in the province within distinct settings and at distinct decision levels. Through the collaborative exploration of Indigenous PHC innovations from other jurisdictions, priorities, enablers, and contextual considerations for achieving policy reform were identified. What follows is an outline of that gathering’s process, illustrating a deliberative moment for mobilizing expert stakeholders towards an innovation agenda. We argue that the political, social, and infrastructural complexity of Indigenous PHC in Alberta offers transferable insights for health policy reform in other areas dogged by limited resources and isolation between stakeholders.

3. Mobilizing stakeholders

The Innovating Indigenous Primary Care in Alberta gathering brought together Indigenous leaders, provincial health system leaders, PHC practitioners (i.e., physicians and nurses), and scholars to dream big about what Indigenous PHC should and could look like in the province. Approximately sixty-five (n = 65) Alberta stakeholders gathered to explore how partners could collaborate to move an Indigenous primary health care agenda forward, while engaging the diversity of cultural, geographic, jurisdictional, and Treaty contexts within the province. The size of the invited stakeholder group (i.e., audience members, breakaway session participants) was strategic—large enough to allow discussions among inter-professional groups, and small enough to allow for summative attention to move an agenda forward. A guiding principle affirmed by the convener, the University of Calgary’s Department of Family Medicine, was respect for Indigenous self-determination, including Indigenous community decisions on the leadership and service providers to act in their interests. This meant that invitations to the gathering were extended to individuals in the province fulfilling roles as health directors of primarily Indigenous PHC services, medical leads, and those carrying regional or tribal health portfolios. Preparation included consultations with an expert advi-
sory group (n = 6) of Indigenous and physician leaders. Stakeholders in attendance brought perspectives from a range of sectors and levels of government, including Indigenous community health leads from First Nations in Treaties 6, 7, and 8 territories, health service providers working both on- and off-reserve, physicians affiliated with the province’s Aboriginal Alternative Remuneration Plan (ARP) for providing care to Indigenous patients outside of a fee-for-service model, and PHC scholars (Table 1).

3.1. Process

The gathering began with stakeholders from diverse Indigenous contexts (e.g., rural/remote, urban) and perspectives (e.g., community, leadership, physician, nursing, health director roles) to collaboratively engage with and ask questions of three out-of-province guests who presented their experiences from forging innovations in similar jurisdictions. An urban-based presenter group shared experiences with establishing an Elder spiritual support program for Indigenous patients in an inner-city Vancouver PHC clinic in British Columbia serving patients from dozens of cultural backgrounds across Canada. Another presenter shared experiences from a partnership between five Mi’kmaq reserve communities in Nova Scotia that harnessed management of community health indicators for improved planning and coordination of services. A last presenter shared systems-level experiences from a clinic in remote northern Quebec that provides care to an expansive region inhabited by primarily Cree communities. All guests emphasized that their innovations in PHC engendered significant improvements both in delivery of and access to PHC.

3.2. Facilitation

For the first half of the gathering, approximately twenty Alberta stakeholders and researchers gathered in each of three available boardrooms to engage in three rounds of 1-h breakaway sessions. Each session involved a 20-min presentation followed by 40-min facilitated discussion in response. Guest presenters described key features of their innovations, supports and resources, collaborations, and evaluation processes. In each session, an expert facilitator experienced in providing PHC to Indigenous people in Alberta guided discussions, treating the presentations as case studies for exploring applicability of the models within Alberta contexts. Centering an Indigenous framework for assessing the appropriateness of service delivery, the facilitation strategy (see Fig. 1) was adapted from the Public Health Agency of Canada’s Aboriginal Ways Tried and True (WTT) portal, a database of health interventions occurring in Indigenous communities identified for addressing cultural relevance, inclusivity, and appropriate validation structures (http://cbpp-pcpe.phac-aspc.gc.ca/aboriginalwtt/). Discussions focused on assessing: 1) innovations in terms of Alberta’s unique funding, infrastructure and political realities; 2) opportunities and challenges for improving Alberta-based PHC through such models; and 3) core actions and recommendations emerging from discussions for engaging decision-makers to champion an innovation agenda.

3.3. Synthesis

The three rounds of presentations and facilitated discussions were then summarized to the wider group by the expert facilitators, who had remained with the same presenters throughout. This was followed by a high-level synthesis of observations by the former Chief Public Health Officer of Canada, Dr. David Butler-Jones (2004–2014), who drew on experiences from the inception of that role to offer insights around the challenges and possibilities of forging systemic change. The event concluded with a large group discussion to develop action statements around the need for struc-

4. Results

Stakeholders highlighted commonalities across the models of PHC shared, including the value of incorporating Indigenous knowledge systems and cultural protocols, and of adopting holistic approaches to PHC delivery for Indigenous communities see Table 2.

4.1. Priorities for an innovation agenda

4.1.1. Outreach

Key elements of success emphasized in each presentation was having a coherent model for community engagement, which may occur as outreach to populations served or as support for staff often coming from outside of communities. In the case from northern Quebec, this involved representation of the community clinic on relevant professional, regional, and provincial bodies. Another means envisioned for building capacity within communities to sustain innovative services was pursued through encouraging community youth and post-secondary students to consider careers in the health professions. Often from outside the remote region, staff involvement in local activities and ceremonial aspects of community life were encouraged to develop cultural competency and role models to link youth to science and other academic resources.

4.2. Enablers of policy reform

4.2.1. Existing networks & infrastructure

Responding to innovations shared, participants emphasized the importance of learning from beyond the health sector about how to meet the health priorities of Indigenous communities. For instance, Elder involvement in criminal justice initiatives were highlighted as central to disbanding gangs, which in turn was seen to prevent violence and injury. Meanwhile, health system resources identified for supporting innovation included telehealth infrastructure (i.e., connecting remotely located providers through telecommunications technology), which could be mobilized to link Indigenous
<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Policy Level</th>
<th>Location</th>
<th>PHC Expertise</th>
<th>Role at Gathering</th>
<th>Engagement Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Canada’s First Nations &amp; Inuit Health (FNIH) branch</td>
<td>Federal</td>
<td>Ottawa; regional offices in Edmonton &amp; Calgary; reserve community health services</td>
<td>Non-physician services, primarily focused on public health initiatives</td>
<td>Provincial primary care lead served as facilitator for reserve-based break-away discussions &amp; on expert advisory group; former Chief Public Health Officer of Canada provided synthesis.</td>
<td>Identifiable leadership in federal and regional roles; early invitation of regional lead to join advisory group</td>
</tr>
<tr>
<td>Alberta Health Services</td>
<td>Provincial</td>
<td>In cities, towns &amp; rural areas throughout Alberta across primary to tertiary systems</td>
<td>Nursing and allied health personnel; healthcare administration; transitions across levels of care</td>
<td>Former and current provincial medical leads served as facilitator for system-level break-away group discussions &amp; on expert advisory group</td>
<td>Identifiable leadership in provincial &amp; Indigenous Health Program roles; early invitation of leads to join advisory group</td>
</tr>
<tr>
<td>PHC Innovators from Similar Jurisdictions Outside Alberta</td>
<td>Health Service Delivery</td>
<td>• British Columbia • Nova Scotia • Quebec</td>
<td>• Integrating Indigenous knowledge into clinical practice • Health data administration • Structuring health &amp; social services delivery on Indigenous approach to wellness</td>
<td>Present innovations in Indigenous PHC from elsewhere in Canada in 3 cycles to rotating audiences, answering questions and engaging ideas during facilitated breakaway discussions</td>
<td>Conducted environmental scan of PHC service innovations in Canada, USA, Australia and New Zealand; identified thematic grouping around system, urban &amp; remote/rural innovations; recruited 1 presenter group in each of these from distinct geographic regions in Canada</td>
</tr>
<tr>
<td>Indigenous Health Services Leadership</td>
<td>Community-level</td>
<td>Treaty 6, Treaty 7, Treaty 8 regions; urban &amp; Métis service organizations</td>
<td>Community self-identified needs &amp; priorities</td>
<td>Break-away discussion participants responding to presentations, contextualizing innovations to their respective contexts; 2 reserve-based health directors served on advisory group</td>
<td>Strategically identified Indigenous communities in Alberta through environmental scan with some activity around PHC innovation; reached out to health directors &amp; medical leads with gathering invitation; also invited regional health leads within Treaty 6, Treaty 7, and Treaty 8 organizations. Transportation &amp; accommodation for community partners was provided.</td>
</tr>
<tr>
<td>Academic</td>
<td>Connected though outside of government, health services, &amp; community domains</td>
<td>Calgary &amp; Edmonton, Alberta Winnipeg, Manitoba Kingston, Ontario</td>
<td>Training of resident physicians; models of care, health policy &amp; system integration research</td>
<td>• ANONYMOUS convened expert advisory group, conducted environmental scan to identify innovative models for inviting guest presenters, secured funding to convene event &amp; table final report • University of Alberta partner served on expert advisory group • University of Manitoba guest provided keynote speech on evidence for Indigenous-focused PHC strategy • Queen’s University partner served as expert facilitator in large group discussions</td>
<td>National leaders in Indigenous primary care innovation were identified through academic team networks and invited to contribute to expert advisory group and facilitation roles.</td>
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patients living outside of their home territories with their own cultural Elders for spiritual support and guidance on healing journeys.

4.2.2. Opportunistic resourcing

Presenters acknowledged that program funding for their innovations came from a patchwork of research and service initiatives, with no guarantee of their innovations’ incorporation into permanent services, rendering their work vulnerable to annual project funding cycles. Such cycles had nevertheless been harnessed for innovations in the first place, such as with the Elder program’s emergence from funding to address mental health rather than funding for spiritual supports now provided by the program.

4.3. Contextual considerations

Stakeholders noted that physician services in Alberta are not funded through Health Canada, the main PHC provider in most remote and northern First Nations communities. This poses difficulties for some organizations to resource clinical services, in turn making it difficult to attract physicians to practice in remote northern areas. It also fueled challenges to ensuring that part-time visiting physicians in remote communities collaborate with local clinical staff, including community health nurses and home care workers who more consistently interface with local communities. While Health Canada nurses (and nurse practitioners in certain contexts) have a primary care function comparable to physicians in some northern First Nations, it was noted that the majority of reserve communities are not funded by Health Canada to provide “primary care” (i.e., physician services) but rather PHC, that is, mainly public health interventions (e.g., vaccination).

4.3.1. Incomplete resources

Stakeholders expressed dismay that small budgets for First Nations PHC undermine its very existence, raising questions about how to ensure well-funded systems in remote areas. Indigenous communities in the province have a wide range of capacity, with some having more flexible funding agreements with federal and provincial authorities than others. Improved data management was identified by attendees to be crucial in such contexts, as means of identifying community service needs for allocating scarce resources. Communities having gained control over their health data affirmed that such control helps them address discontinuity of care issues by targeting, for instance, physician turnover and fly-in/fly-out services often provided by non-Canadians filling a workforce gap who are unfamiliar with local contexts. Persistent shortage of allied health professionals like nurses, physiotherapists, and mental health workers, as well community health workers or traditional healers was pervasive.

5. Pathways for policy reform

The explorations among stakeholders highlight possibilities for lateral collaborations to improve organization, planning, and delivery of PHC through meaningful dialogue between Indigenous community leadership, service providers, administrators and patients. Each of the cases under consideration emphasized flexible policies, programs, and services, as well as opportunistic approaches to funding PHC innovations. One overarching challenge identified was that PHC in Indigenous contexts in Alberta lacks a sustained approach that allows resourcing to implement, evaluate, and eventually innovate models. While lack of service coordina-
tion is one consequence, so too is limited community engagement in shaping services moving forward.

Some stakeholders wondered whether it was even possible for Indigenous communities in Alberta to achieve a similar level of service coordination as the AHACs in Ontario or the FNHA in British Columbia, believing that in those provinces much decision-making occurs at a regional instead of provincial level. The provincial integration process of Alberta’s regional health services in the past decade was seen by stakeholders to inhibit localized action to make PHC responsive to diverse patient and community needs. Government commitment to shared decision-making was one key principle identified by stakeholders as essential for moving an Indigenous PHC innovation agenda forward; other principles included community engagement, self-determination, the involvement of local champions, and evaluation capacity.

Expert stakeholder insights from the gathering indicate a roadmap for action around which partners can come together. This is composed of implementation priorities ranging from on-the-ground management of PHC to involvement in structural supports to make innovations possible. Derived from conversations around innovations across jurisdictions, these strategies should resonate beyond Alberta (Table 3).

The gathering was an opportunity for diverse stakeholders invested in improving Indigenous PHC to come together for discussion in a practical and non-threatening manner that crosses pockets of existing innovation. The range of responses to innovations shared highlighted a need among stakeholders to continue exploring possibilities, in order to develop a shared knowledge base from which to make policy decisions with greater partnership. Building further rapport is needed, as is more understanding of one another’s activities and of existing Indigenous-focused services within Alberta. The gathering was a first bid at forming an inter-professional community of practice committed to improved PHC for Indigenous persons in Alberta. Convened outside of the direct mandate of policy and health service delivery, and therefore accountable only to the Indigenous communities who deserve improved care, the process outlined here also enhances stakeholder capacity within diverse institutions to critically explore the health care implications of the TRC’s calls to action.

6. Conclusion & next steps

Despite growing opportunity for Indigenous-focused PHC in Canada, innovations in specific policies and frameworks for community-led health service delivery are limited, with system-wide models concentrated in Ontario and British Columbia. More is needed to achieve a system-level course correction. Whether recognized or not, successes in health care reform internationally are deeply linked to public consultation [17], whereby change often emerges through sustained and collaborative knowledge exchange. Nevertheless, additional support for integrating research to guide and assess innovations is needed [18]. Stakeholders identified that dedicated infrastructure is crucial to reform, such that a centre of excellence committed to Indigenous PHC would be opportune to strategically frame clinical services within a population health approach. Current system resources that could be enhanced to support such work could involve forging a provincial Indigenous primary care directorate with community leadership in shaping health care delivery models, or a collaborative centre housed within or beyond academia that helps to map Indigenous PHC innovations and to push capacity for appropriate evaluation forward. From this perspective, the gathering described here is but one type of forum, a congress of sorts, aimed at helping stakeholders come together. While limited to conversation, it allowed key actors with diverse portfolios to explore and gain new capacity in an area long neglected by wider health systems. In November 2017, the provincial health services authority reconvened a stakeholder gathering to take up conversations stirred in the January 2016 gathering; an initial investment by academic partners to move an agenda forward has triggered modest momentum for stakeholders to come together in new ways and with focused energy for reform.

Conflict of interest

The authors declare no conflicts of interest.

Acknowledgements

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Table 3

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<thead>
<tr>
<th>Domains of Action</th>
<th>Priority Actions</th>
<th>Outcome Measures</th>
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<tbody>
<tr>
<td>Governance</td>
<td>• Embed Indigenous representation at College of Physicians and Surgeons of Alberta (CPSA) board</td>
<td>Decolonize health data collection and service evaluation by re-orienting outcome measures according to patients needs and populations served</td>
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<td></td>
<td>• Promote diverse Indigenous representation in provincial/federal health services leadership</td>
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<tr>
<td>Financial</td>
<td>• Allocate adequate funding and facilitate flexible funding agreements</td>
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<tr>
<td>Service Administration</td>
<td>• Establish corridors of care based on treaty and community guidance</td>
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<tr>
<td></td>
<td>• Stop harmful short-term/episodic service delivery models</td>
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<td></td>
<td>• Ensure equitable community and Elder engagement/remuneration in PHC delivery</td>
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<tr>
<td>Community</td>
<td>• Create a patient/population registry with community ownership and control of data</td>
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References


