



SUPPORTING INDIGENOUS SELF-DETERMINATION IN HEALTH:

*Lessons learned from a review of best practices in health
governance in Canada and internationally*

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National Collaborating Centre
for Indigenous Health



Centre de collaboration nationale
de la santé autochtone

SOCIAL DETERMINANTS

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INTRODUCTION



It is well documented that Indigenous Peoples¹ around the world experience poorer health status in comparison to non-Indigenous populations. There is a considerable body of international evidence that shows these health disparities are linked to complex interactions between historical and contemporary structural, social, political, economic, and environmental factors that influence populations across their life span, referred to as the social determinants of health (George, Mackean, Baum, & Fisher, 2019; Jackson Pulver, Waldon, & Harris, 2015; Jones et al., 2019; Lines & Jardine, 2019; Reading & Wien 2013). As far as they affect Indigenous Peoples, these disparities have proven to be deep, enduring, and resistant to government efforts to address them (Angell, 2017). While there have been a number of global achievements related to improving population health, the continued poorer health status of Indigenous Peoples around the world illustrates the impact

of systematic, socially produced, and unfair policies and practices on the presence of disease, health outcomes, and access to health care (Anderson et al., 2016; Kirmayer, & Brass, 2016).

Indigenous Peoples have long advocated for the right and responsibility to design, deliver, manage, and, ultimately, control their own health programs and services, which many believe is key to closing existing gaps in health outcomes between Indigenous and non-Indigenous populations (Assembly of First Nations [AFN], 2017; Australian Government, 2015; Gottlieb, 2013; Harfield, Davy, McArthur, Munn, & Brown, 2018). Self-determination is one of the most important determinants of Indigenous health and well-being (Reading & Wien, 2013). It is considered essential for empowering and enabling communities to build capacity and gain control over the wide-ranging forces that affect health and well-being at individual and

collective levels (Garces-Ozanne, Ikechi Kalu, & Audas, 2016). While social determinants of Indigenous health and Indigenous rights to self-determination “may be acknowledged in policy rhetoric, ... they are not always a priority for action within policy implementation” (George et al., 2019, p. 1). To achieve equitable outcomes, Indigenous Peoples must be given full access to high-quality, responsive, comprehensive, culturally-relevant, and coordinated health and social services that target the diverse determinants of health, including individual and community self-determination (AFN, 2017; Greenwood, 2019; Jones et al., 2019). In recognition of this, governments in Canada and internationally have committed to health systems reform to address health inequities and determinants of Indigenous health, support Indigenous self-determination, and influence better health outcomes for Indigenous Peoples (Alberta Health Services, 2018;

¹ The term “Indigenous Peoples” is used throughout this paper to refer collectively to the original or earliest inhabitants of a region, within Canada and internationally, as opposed to people who moved for the purposes of settling, occupying or colonizing these areas. In Canada, the term Indigenous Peoples is used to refer collectively to First Nations, Inuit, and Métis Peoples, as defined under Section 35 of the Canadian Constitution of 1982. When referring to a specific Indigenous group, the specific terms (First Nations, Inuit, and Métis) will be used.

AFN, 2017; Atlantic First Nations Health Partnership [AFNHP], 2016; Australian Government, 2015; Gottlieb, 2013; Jackson Pulver et al., 2010; Jones et al., 2019).

This paper provides a targeted review of the literature on various models of Indigenous health governance between 2000 and 2019. The purpose is to inform Indigenous Services Canada's (ISC) work to create new health governance structures and funding models in Canada. The ISC is tasked with closing socio-economic gaps and advancing self-determination, in partnership with First Nations, Inuit, and Métis Peoples (ISC, 2019a). Part of the federal department's plan includes improving access to primary health care and social services for Indigenous Peoples and advancing the transformation of health services toward greater ownership, control, and management by Indigenous Nations. Accordingly, the Department is exploring options for creating new health governance structures and funding models for Indigenous communities to support the devolution of services and self-

determination. The literature review is limited to Canada, Australia, Aotearoa (New Zealand), and the United States. The review provides strong evidence that no one model of health governance exists for all communities. Models must be designed by the communities themselves to fit their unique needs.

This report is organized into four substantive parts.

- Part 1 describes the methods used to identify relevant literature and extract information.
- Part 2 provides an overview of the factors that affect Indigenous health and the context of Indigenous health governance in Canada.
- Part 3 describes examples of health governance structures and funding models currently in place in Indigenous contexts globally and nationally. Finally,
- Part 4 synthesizes key findings and lessons learned from existing examples of health governance structures and funding models.

PART I: METHODS



The targeted literature review aimed to identify sources of information on primary healthcare models that are designed to meet the unique needs, priorities, and distinct circumstances of Indigenous Peoples, support good governance, and advance their vision of self-determination through the progressive and successful devolution of services to Indigenous Peoples. This section describes the methods utilized to identify relevant literature, including the research questions, inclusion criteria, and search strategy, as well as the methods used to extract information.

It is generally acknowledged that Canada, Australia, New Zealand, and the United States share a common language, enjoy a long history of collaboration with each other, and have well-established statistical systems for exploring and reporting on current events. They also share similar histories of Indigenous colonization, face significant problems in the collection of accurate data on Indigenous Peoples, including, specifically, on health, and pursue comparable processes

for healthcare reform (Jackson Pulver et al., 2010). Thus, our search for successful models of health governance and funding arrangements with Indigenous communities generally targeted these countries. It is important to acknowledge, however, that while these countries share similar colonial histories, their State government systems, laws, regulations, and practices are very different. Likewise, First Nations, Inuit, and Métis in Canada share similar colonial histories, yet they are distinct, with unique health governance arrangements depending on their scope of delivery, population, and geographical location. In short, what works in one particular context may not necessarily work across all Canadian contexts.

The data collection was guided by the primary research question, “How should governments organize their business to support self-determination for Indigenous Peoples?” Secondary research questions to help inform this policy direction include:

1. Which governance models support self-determination for Indigenous Peoples and

have shown some success in addressing health inequities that may be transferable to the Canadian context?

2. What were the particular supportive and inhibiting factors, including contexts, which influenced the development and implementation of these governance models?
3. How can successful self-determination be measured?
4. How are Indigenous ways of knowing, the social determinants of health, the wellness continuum, and engagement/partnership reflected in government governance models and associated accountability frameworks?

The inclusion criteria for the literature review targeted both peer-reviewed and grey sources that were written in English, focused on Indigenous health, and were published between 2000 and 2019. These sources were searched to identify additional relevant sources, which revealed the need to change the date parameters to include years prior to 2000, as several international health governance

models that remain in existence were established earlier than that year. In cases where gaps in information were identified for specific models of health governance, a targeted search was undertaken in an effort to fill those gaps. This involved searching Google and using the particular health governance model as a search term together with a term reflecting the missing information (e.g., funding arrangement, accountability, quality improvement). Only freely accessible sources of information were included in this review. Wherever possible, literature by Indigenous authors and/or community-based participatory literature was emphasized to highlight Indigenous perspectives.

Search strategy

An online data search was conducted of Google, Google Scholar, PubMed Central, Research Gate, BioMed Central, Science Direct, désLibris Canadian Electronic Library, and Open Access Thesis and Dissertations databases. A combination of key phenomenon and population search terms were used, including Indigenous, Aboriginal, First Nations, Inuit, and Métis in combination with health services, health governance, accountability frameworks, Indigenous-government partnerships, devolution, health policy reform, ways of knowing, self-

determination, community controlled services, collective impact approaches, health funding, complex environments, and sustainable community development. The first webpage of sources (20-50 items) resulting from each database search was scanned for possible information relating to the research questions. The title, authors, abstract, and keywords of each source were screened for compatibility with the inclusion criteria. Open access items selected for further review were downloaded and cited in a reference list of potential sources of evidence.

There are some limitations to this search strategy. For example, the exclusion of terms for specific Indigenous groups, such as Cree or Anishinaabe, and the narrow focus on Indigenous health and health determinants search terms may have resulted in a literature gap, given the holistic perspectives of health and well-being among diverse Indigenous groups and the distinctiveness of Indigenous populations. Likewise, First Nations principles of Ownership, Control, Access, and Possession (OCAP®) with regard to principled research, data sovereignty, and information governance may restrict the entry of community research into the public realm. This search strategy also did not utilize systematic review protocols. Nevertheless, it does provide a fairly comprehensive review of the literature in this field.

Information extraction

Review, selection, and data extraction were undertaken. The abstracts of downloaded sources were read in detail, full texts were reviewed, and data were extracted, based on the primary and secondary research questions related to federal health policy. Additional referenced sources of information that evolved from the selected sources were downloaded and subsequently reviewed as part of the literature review. Approximately 127 sources were downloaded for review. Information sources included academic articles, research journals, governance documents, theses, and dissertations. Recurring themes were identified from the selected sources, and information related to theme topics were compared and assessed in conjunction with the research questions. Material that was deemed relevant, appropriate, and useful to inform new health governance structures and funding models for Indigenous communities was included in the summary of reviewed literature. Additionally, contextual information was derived from the websites of federal and provincial governmental departments and agencies, and from Indigenous health organizations.



Addressing the determinants of Indigenous health means acknowledging that the concept of health extends beyond physical elements to include a range of factors that influence the physical, mental, spiritual, and social well-being of Indigenous Peoples.

(Alberta Health Services, 2018; Wilmot, 2018).

PART II: THE CONTEXT OF HEALTH GOVERNANCE FOR INDIGENOUS PEOPLES IN CANADA



This section summarizes some of the key themes that need to be considered in the development of new health governance structures and funding models to achieve equity in Indigenous health in Canada. Specifically, it discusses the determinants of Indigenous health within the context of health policies and programs, the barriers to care experienced by Indigenous individuals, the structure of existing Indigenous health governance and funding arrangements, and changes to the health system landscape in Canada.

The determinants of Indigenous health and well-being

Addressing the determinants of Indigenous health means acknowledging that the concept of health extends beyond physical elements to include a range of factors that influence the physical, mental, spiritual, and social well-being of Indigenous Peoples (Alberta Health Services, 2018; Wilmot, 2018).

The circumstances and environments that determine the development and maintenance of health for Indigenous Peoples were categorized by Reading and Wien (2013) into three dimensions: proximal, intermediate, and distal determinants. *Proximal determinants* have a direct impact on the physical, emotional, mental, and spiritual health of Indigenous Peoples and include health behaviours and one's physical and social environment. *Intermediate determinants* represent the origin of proximal determinants and include community infrastructure, resources, systems, and capacities. *Distal determinants* underlie the construction of both intermediate and proximal determinants and include the historic, political, social, and economic contexts of Indigenous Peoples' lives. Distal determinants have the most profound effects on the health of Indigenous Peoples and are the most difficult to change. However, if they are addressed, distal determinants can also have the greatest impacts on health outcomes and long-term change on health inequities.

Health inequities are generally caused by the unfair distribution of power, income, goods, and services. Their consequences are evident not only in limited access to health care, education, work, and leisure but also in the relative health of diverse communities (George et al., 2019; Reading & Wien, 2013). In Indigenous contexts, deeper causative social, environmental, and socio-economic factors contribute to the poorer health status of Indigenous Peoples when compared to the general population. These include psychosocial factors, such as dispossession, racism and life stresses; economic factors related to income and employment; educational factors, such as literacy, numeracy, school attendance, and completion levels; community factors related to local capacity, family functioning, safety, and criminal involvement; as well as factors related to the physical environment, such as overcrowded housing and inadequate transportation (Donato & Segal, 2013; Reading & Wien, 2013). These causative

factors of health are found outside health systems, which present challenges for creating government policy because they require consideration beyond the conventional boundaries of health systems. Thus, primary health care is recognized as central not only to dealing with chronic disease but also to providing a multidisciplinary framework that involves other sectors that are also engaged in tackling Indigenous disadvantages or inequities.

A common element that affects virtually every issue confronting Indigenous Peoples in Canada and throughout the world is colonization, with its associated subjugation and marginalization. Research has shown that the health of Indigenous Peoples has been, and continues to be, shaped by common global colonial structures, policies, and practices. Structural violence – that is, the disadvantage and suffering that stems from structures, policies, and institutional practices that are innately unjust – is a major determinant of the distribution and outcomes of social and health inequities. It shapes the health of Indigenous Peoples and communities, and is deeply embedded in history, individual and institutional racism, and inequitable social policies and

practices that continue to exert effects on First Nations, Inuit, and Métis Peoples.

Racism is one dimension of colonization that has had a negative influence on how Indigenous Peoples are perceived and positioned in Canadian society (Angell, 2017; Browne et al., 2016; Czyzewski, 2011; George et al., 2019). For instance, the traumas experienced by First Nations, Inuit, and Métis individuals as a result of racist policies and practices have had detrimental effects on multiple generations of Indigenous Peoples. These policies and practices include the creation of reserve lands and inadequate resources to sustain an acceptable quality of life, and the apprehension of Indigenous children (first through residential schools, then through the Sixties Scoop² and the continued removal and placement of Indigenous children into foster homes today). The legacy of colonization, systemic racism, and other forms of discrimination contribute to the current lack of employment opportunities, limited access to education, inadequate housing, and high levels of poverty experienced by Indigenous Peoples in Canada and throughout the world (Browne et al., 2016).

Loss of self-determination and control over the matters that affect their daily lives is another feature of colonization that has contributed to Indigenous Peoples' poorer health outcomes and remains an ongoing barrier to improving outcomes (Saulnier, 2014). Loss of self-determination has been a source of much frustration, anger, resentment, insecurity, and despair for Indigenous Peoples around the world. It has led to tragic physical and mental health outcomes, including high rates of suicide, depression, alcoholism, and violence (Chandler & Lalonde, 1998, 2008; Kirmayer, Brass, & Tait, 2000). Greater self-determination can empower Indigenous Peoples to take control of their health and well-being. It can foster ownership that will lead to better healthcare services and health outcomes (Auger, Howell, & Gomes, 2016; Chandler & Lalonde, 1998; Murphy, 2014). While self-determination does not necessarily mean that Indigenous Peoples have full control over the delivery of healthcare services in their communities, it does mean they have the right to decide the level of control they wish to have (AFNHP, 2016).

² The Sixties Scoop refers to a period in Canada's history where thousands of Indigenous children were removed from their families by child welfare authorities and fostered out to non-Indigenous families. While the Sixties Scoop refers to the 1960s, these apprehensions began during the late 1950s and continued over several decades (First Nations Studies Program, 2009).

There are opportunities for governments and health leaders at all levels to address the determinants of Indigenous health that originate outside the healthcare system. These determinants include housing, education, employment, poverty, food security, water safety, social supports, early childhood development, the environment, and colonialism. Determinants such as racism and socio-cultural and political sovereignty have significant impacts on Indigenous health outcomes, but they can be addressed through progressive policies (Richardson & Murphy, 2018). Other determinants of health can impact Indigenous people's ability to access health services. These include unemployment, lower levels of education, and the health care practitioners' ability to understand and take account of local beliefs and values when providing care. Healthcare services that are both cognizant of and able to address the determinants of Indigenous health relevant to their particular contexts are crucial for improving access to healthcare services and ensuring these services respond to the unique cultural, historical, and social fabric of the communities they serve (Davy, Harfield, McArthur, Munn, & Brown, 2016).

Social determinants of health and Indigenous rights are not always recognized within government policy, and when they are, they

are not always a priority for action within policy implementation. In their scoping review of international literature, public policy, and Indigenous health to explore the implementation of social determinants in health policy, George and colleagues (2019) found that while self-determination may be included in policy rhetoric, it tends to be in token ways. That is, when self-determination was named, it did not necessarily lead to recommendations or strategies for action. When it did, the recommendations or strategies tended to be either limited in scope or not viewed as a priority within health care but as a recommendation that fell outside the scope of the health sector. This failure to adequately address social determinants in policy is a prevalent issue across colonized countries, resulting in Indigenous Peoples globally experiencing health inequities and lower life expectancies compared to non-Indigenous people. Policy research can help to advance understanding of more effective ways to address determinants of Indigenous health and promote the fair distribution of health in society (George et al., 2019).

Due to Indigenous Peoples' experiences with colonialism and resulting disparities in the determinants of health, health equity considerations must be at the forefront of all health policy and program development related to First Nations, Inuit, and Métis

populations. Browne et al. (2016) discussed specific strategies for promoting equity-oriented care that takes Indigenous Peoples' colonial history into account and supports their agency and resistance to subjugation. These strategies are situated within an inequity-responsive care framework that pays "explicit attention to the provision of culturally safe care, trauma- and violence-informed care, and contextually tailored care" (p. 4).

Loss of self-determination and control over the matters that affect their daily lives is another feature of colonization that has contributed to Indigenous Peoples' poorer health outcomes and remains an ongoing barrier to improving outcomes.

(Saulnier, 2014).



The authors identified four general approaches to enact strategies that operationalize equity-oriented care for Indigenous Peoples:

1. Developing partnerships with Indigenous Peoples;
2. Taking action at all levels (patient-provider, organizations, systems);
3. Paying attention to local and global histories; and
4. Attending to unintended and potentially harmful impacts of each strategy.

They then identified and discussed how 10 intersecting strategies can optimize the effectiveness of healthcare services for Indigenous Peoples and their implementation. These strategies are: making a commitment to fostering health equity; developing supportive structures, policies, and processes; creating a welcoming milieu; re-visioning the use of time in providing care; continuously attending to power differentials; tailoring care, programs, and services to local Indigenous contexts, cultures, and knowledge systems; actively countering systemic and individual experiences of racism and discrimination; ensuring opportunities for meaningful engagement of patients and communities; tailoring programs and services to address interrelated forms of violence; and tailoring care to address the social determinants of health for Indigenous Peoples.

Barriers to accessing health programs, services, and resources for Indigenous Peoples

Indigenous people face numerous barriers to accessing health programs, services, and resources that can directly and indirectly impact their health outcomes and contribute to ongoing health disparities. These barriers relate to the accessibility, availability, and acceptability of health programs and services. They stem from colonialism, geographic location, health system deficiencies, inadequate and inappropriate health information and human resources, jurisdictional fragmentation, poor communication practices, and lack of cultural safety and traditional approaches to ensuring well-being. Barriers may also be financial or cultural, or they may be related to health literacy (Angell, 2017; AFNHP, 2016; Ashworth, 2018; Davy et al., 2016; Donato & Segal, 2013; National Collaborating Centre for Indigenous Health [NCCIH], 2019; Richardson & Murphy, 2018). In a scoping review of models of service delivery implemented within primary healthcare services that predominantly provided care to Indigenous Peoples, Davy et al. (2016) identified nine characteristics of access to and accessibility of Indigenous health services:

1. The ability of people to perceive they need and want care (*ability to perceive*);
2. The degree to which individuals know a healthcare service exists (*approachability*);
3. The appropriateness of a healthcare service in relation to the social and cultural norms of the communities they serve (*acceptability*);
4. The ease with which Indigenous individuals can access healthcare services when they need it (*ability to reach*);
5. The ability to reach healthcare services in a timely manner (*availability and accommodation*);
6. The ability of individuals to pay for healthcare services;
7. The expenses incurred in running a healthcare service (*affordability*);
8. The ability of an individual to engage with the care that is offered; and
9. The extent to which the care provided meets the needs of the communities they serve (*appropriateness*).

The authors found that many interrelated factors influenced access to and acceptability of healthcare services. The broader healthcare system, rather than a particular service or the user, appeared to influence access to and acceptability of care. Funding was the most obvious system issue identified, as Indigenous community-controlled healthcare services operated within

constrained budgets, resulting in a reduction of services for Indigenous Peoples. The ability to pay for health services and the ability to reach health services (e.g., cost of transportation) were key barriers to accessing care. As well, the ability to engage with the care offered was important to both health care acceptability and appropriateness.

Having reasonable and equitable access to health services facilitates earlier diagnosis, reduces mortality, and improves physical, mental, emotional, and social outcomes (NCCIH, 2019). Although Canada's health care is universal, the system is inequitable. Indigenous Peoples do not experience the same access to health services as other Canadians. This is especially the case in rural and remote northern communities, where the largely Indigenous populations face challenges recruiting and retaining general health practitioners and lack access to specialized health services (NCCIH, 2019). Indigenous patients often face critical shortages of medical personnel, long wait-lists, culturally unsafe care, and challenges with accessing non-insured health benefits (NIHB), a national insurance policy for status First Nations and Inuit people regardless of their residence. They must also travel frequently and over long distances to urban centres for medical emergencies, hospitalization, and specialized

health services, resulting in their being away from the support of family and friends (NCCIH, 2019). Inequitable funding for Indigenous health programs and services, compounded by complex, ambiguous, and fragmented jurisdictional issues, has resulted in confusion, frustration, and unmet health care needs. This has in turn led to higher mortality and morbidity rates among Indigenous Peoples (Greenwood, de Leeuw, & Lindsay, 2018; Lavoie et al., 2015). There are also challenges to equitable access to health programs and services across First Nations, Inuit and Métis populations. The federal government has responsibility for providing registered First Nations and Inuit with funding for the delivery of community-based health promotion and disease prevention programs; home and community care; programs to control communicable diseases and address environmental health issues; and supplementary health benefits through the NIHB program. Métis and non-status 'Indians' rely on mainstream health services, and despite the 2016 ruling of the Supreme Court of Canada in its judgement in *Daniels v. Canada* that Métis and non-status Indians are considered "Indians" under section 91(24) of the Constitution Act (1867), it remains unclear whether these populations will receive similar programs and benefits as First Nations and Inuit (Lavoie, 2018). In this context, little attention

has been paid to their specific cultural or geographical needs (NCCIH, 2019).

Accessible health care involves much more than simply locating services within or close to Indigenous communities or reaching healthcare services. It also involves Indigenous Peoples engaging with, and staying engaged with, health care over time (Davy et al., 2016). This requires that health programs, services, and health information be appropriate to the context of Indigenous communities and acceptable to Indigenous individuals. Many Indigenous people do not trust mainstream health programs and services. They perceive them as ineffective not only because of their previous negative encounters with the health system, but also as a result of the fact that the underlying social contexts of Indigenous Peoples is often not taken into account in mainstream health settings, programs, and services (Browne et al., 2016; Cameron, del Pilar Carmargo Plazas, Santos Salas, Bourque Bearshin, & Hungler, 2014; Goodman et al., 2017; Rice et al., 2016; Wylie & McConkey, 2019). For example, despite evidence linking trauma and violence to multiple health problems, rarely are these factors considered in the design and delivery of healthcare services for Indigenous Peoples (Browne et al., 2016). Access to primary healthcare services can improve when services are tailored to meet

the needs of Indigenous Peoples and are owned and managed by communities because they have a better understanding of the social and cultural determinants of health that their community members face. Indigenous healthcare services are more likely to be free of racism, are generally more culturally appropriate than mainstream services, and employ Indigenous staff who know the local language (Davy et al., 2016). Having self-determination over health programs and services allows Indigenous communities the freedom to make decisions that best reflect the values and priorities of their community members. By managing and delivering health care in their communities, Indigenous people are empowered to increase community awareness of health issues, more culturally-informed health care is delivered, more employment opportunities exist for community members, and ultimately, their health status is improved (AFNHP, 2016; Laliberté, Haswell-Elkins, & Reilly, 2009; Richmond & Cook, 2016).

Removing barriers to healthcare access is thus an important aspect of achieving health for Indigenous Peoples. Health programs and services must be culturally appropriate, safe, and

patient-centred. This means they must be perceived as being free from biases, racism, and discrimination. They must respect and meet the unique and holistic care needs of Indigenous Peoples; this means extending practices to include Indigenous concepts of health and well-being³ and incorporating cultural and traditional practices that complement or add to biomedical care. There must be a fundamental shift in the balance of power from the care provider to the patient, making patients active agents in decisions about their health care. Finally, services must provide trauma- and violence-informed care to ensure patients are not re-traumatized by their encounters with the healthcare system (NCCIH, 2019). Acceptability of health care can be enhanced by providing cultural competency and safety training for non-Indigenous health care providers; using plain and culturally appropriate language in health care encounters and health education resources; recruiting and retaining Indigenous health professionals; and emphasizing community ownership and authority over health care services (NCCIH, 2019).

The evolving structure of health governance and funding in Canada

One of the main challenges standing in the way of access to health care for Indigenous Peoples is the complicated patchwork of policies, legislation, and relationships that inadequately define Indigenous health systems in Canada. The existing legislation and policy framework has resulted in an uncoordinated, fragmented health system. It has also brought about jurisdictional ambiguity and uncertainty over which level of government has responsibility for delivering and funding health services to specific groups of Indigenous people. What is more, these services are, for the most part, narrowly defined by federal and provincial jurisdictions, mandates, and priorities. Jurisdictional ambiguity exists at all levels of the healthcare system and applies to Indigenous people who may not know how to access health services (Richardson & Murphy, 2018). Jurisdictional ambiguity has contributed to health disparities, especially among First Nations. Richardson and Murphy (2018) argue that what is needed is a

³ Good health and well-being, according to Indigenous Peoples, requires maintaining a balance between mental, physical, spiritual, and emotional dimensions of health. This balance can be achieved by living a “good life” in harmony, reciprocity, and relationship with other human beings and the natural and spiritual worlds (NCCIH, 2019).

stronger legislative framework that is grounded in a distinctions-based approach⁴ to policy, given the diversity and differences that exist among First Nations, Inuit, and Métis Peoples and the legislation and laws limiting traditional Indigenous practices. Restructuring Canada's healthcare systems to include greater First Nations, Inuit, and Métis control over healthcare services may improve their access to culturally appropriate health services and address inequities in their health status (AFNHP, 2016).

Each province and territory administers their own health systems, including primary care, disease surveillance, disease prevention and health promotion services, including for off-reserve First Nations, Inuit, and Métis (Allin & Rudoler, 2016). Most provinces/territories have established regional bodies to deliver publicly funded health services at the local level. Funding for medically necessary hospital, diagnostic, and physician health services is provided by the federal government on a per capita basis through the federal health transfer to provinces/territories, with the stipulation that services must adhere to the

Canada Health Act (1985); that is, services must be publicly administered, comprehensive in coverage, universal, portable across provinces, and accessible to all Canadians. Federal contributions account for approximately 24% of the total provincial and territorial health expenditures (Allin & Rudoler, 2016). Provinces/territories also administer their own health insurance plans to cover benefits (e.g., vision care, dental care, prescription drugs, etc.) that are considered to be outside the parameters of what is considered medically necessary, each with different interpretations, resulting in considerable variability across Canada in terms of the range of services covered and user fees for services not covered.

The federal government plays a direct role in this health system by promoting overall health, and has responsibility for funding and delivering certain health services and programs for specific populations, including Indigenous Peoples. These roles and responsibilities are fragmented across several federal departments, including Indigenous Services Canada (ISC), Crown-Indigenous

Relations and Northern Affairs Canada (CIRNAC),⁵ and the Public Health Agency of Canada (PHAC). ISC works with partners to improve access to high-quality services for First Nations, Inuit, and Métis populations. It has assumed administrative responsibility for the First Nations and Inuit Health Branch (FNIHB),⁶ which supports the delivery of public health and health promotion services to First Nations living on reserve and in Inuit communities. This includes the following: clinical and client care services to approximately 138 remote and isolated First Nations communities; home and community care in 657 First Nations and Inuit communities; community-based health programs, such as healthy child development, mental wellness, and healthy living programs; communicable disease control; environmental public health monitoring and inspections; and the NIHB program (Government of Canada, 2019a). ISC also works with CIRNAC, provincial and territorial governments, and Indigenous organizations through the Health Infrastructure Support Program, which aims to develop sustainable, long-term, integrated solutions to transform health

⁴ A distinctions-based approach means that rather than adopting a pan-Indigenous approach, each area of policy articulates specific First Nations, Inuit, and Métis responses in recognition of their unique rights, interests, and circumstances.

⁵ On July 15, 2019, the Indigenous and Northern Affairs Canada department was dissolved and replaced by two new departments: Indigenous Services Canada and Crown-Indigenous Relations and Northern Affairs. ISC is primarily responsible for improving access to a wide range of services for First Nations, Inuit, and Métis, including health services, while CIRNAC is primarily responsible for renewing relationships with Indigenous Peoples, enabling capacity-building, supporting Indigenous Peoples' vision of self-determination, and leading the federal government's work in the North.

⁶ Formerly administered by Health Canada.

The set funding model means that the community has little control over how money is allocated and there is minimal community accountability for how it is spent. This is because the FNIHB is responsible for the design of programs and sets the performance conditions to be met.



systems and support initiatives that strengthen capacity in First Nations and Inuit communities to address their own health needs by increasing community control over health program design and delivery. The PHAC is responsible for public health, including emergency preparedness and response, surveillance, and infectious and chronic disease control and prevention. It also provides funding for some health initiatives targeted specifically at off-reserve First Nations, Inuit, and Métis populations.

The principle funding mechanism by which individual Indigenous communities gain control over community-based health

services is through the federal government's Indian Health Transfer Policy, administered by ISC. Health transfer funding pays for primary care services and health promotion and prevention activities. Communities may also access additional federal funding targeted at specific health issues, such as oral health, mental health, suicide prevention, substance abuse, family violence, Indian Residential Schools Resolution Health Support, diabetes prevention, injury/illness prevention, nutrition, tobacco control, communicable disease control and management, environmental health, environmental contaminants, clinical and client care, home and community care, and healthy child development programs (Government of Canada, 2015). Both types of federal funding are typically provided through various types of contribution agreements, each with their own terms and conditions. In the past, this contractual environment has been stringent and limited (Richardson & Murphy, 2018); however, in recent years there has been an increasing movement towards more flexible and less onerous funding arrangements. In addition to federal government funding sources, Indigenous communities may also receive some funding from other sources, including provincial governments, local communities, and tribal councils (Palmer, Tepper, & Nolan, 2017; Tompkins et al., 2018).

Contribution agreements can vary in their duration, their method of payment, how funds are managed, the ability to carry forward unexpended funds, reporting requirements, and requirements for program evaluations or audits. The type of funding formula utilized is determined using a risk-based approach. Funding must be spent in accordance with the agreed upon conditions (Government of Canada, 2015). The most rigid agreement, a set funding model, was commonly used in the past. However, as of April 1, 2018, this model is to be used in only rare circumstances. The set funding model means that the community has little control over how money is allocated and there is minimal community accountability for how it is spent. This is because the FNIHB is responsible for the design of programs and sets the performance conditions to be met. In set funding models, communities can only redirect resources within the same sub-sub activity (with ministerial approval); they must complete interim and year-end reports; they cannot carry over unexpended funds to the next fiscal year and must be return them; and there is only one-way accountability for how funds are spent – to the FNIHB (AFNHP, 2016; Indigenous and Northern Affairs Canada [INAC], 2018a). The duration of these types of agreements can span up to three years.

Fixed contribution funding models are utilized in situations where the estimated costs for achieving the recipient's objectives can be reliably obtained through either a funding formula or fixed costs (INAC, 2018a). These types of agreements allow recipients to carry forward unexpended funds in some situations, but they come with the risk that the recipient may be responsible for any cost overruns.

Flexible funding models give a greater measure of control to communities in terms of how funds are managed. They typically require recipients to establish multi-year plans for the duration of the agreement (2-5 years), including a health management structure; however, funds can be reallocated within the same program authority throughout the life of the agreement, and unexpended funds can be carried forward to the next fiscal year within the same program authority. Recipients are required to complete a year-end audit, with accountability resting with the FNIHB.

Block funding models allow recipients to determine their own health priorities (identified in a Health Plan), establish their own health management structure, reallocate funds across all authorities, and retain unexpended funds for reinvestment in priorities.

Recipients are required to conduct annual reports and year-end audit reports. They are also expected to conduct an evaluation report every five years (INAC, 2018a).

In addition to these types of funding arrangements, in some cases there is also the option of a multi-departmental funding agreement (MDFA). This type of agreement is the most flexible because it pools funding from multiple departments under a single agreement, enabling the delivery of multiple social programs, including health, education, child welfare, economic development, income assistance, infrastructure, housing, and local government (Lavoie & Dwyer, 2016). This type of arrangement is most often associated with land claim settlements (e.g., Nisga'a, James Bay and Northern Quebec, and Labrador Inuit Association agreements) and other tripartite agreements between the federal and provincial governments and Indigenous groups. Because these agreements sit outside the usual grant and contribution agreement frameworks and provide Indigenous groups with budgetary flexibility across sectors beyond health, they can facilitate innovative cross-sectoral partnerships and enable cross-jurisdictional linkages that help minimize jurisdictional fragmentation and avoid duplication of services (Lavoie & Dwyer, 2016; MacIntosh, 2008).

As part of the federal government's commitment to establishing a new fiscal relationship with Indigenous communities, a grant approach is also now being considered in the design and delivery of transfer payment programs (INAC, 2018a). Grant models differ from block funding in that they have a longer duration (10 years), and they do not have as many administrative and reporting requirements or as many limitations on eligible expenditures. Recipients are not required to report on results, funds can be used for any duration of time necessary to achieve program results, unexpended funds can be retained for future investments, and recipients have flexibility in designing and delivering programs and services in ways that meet their local needs and changing circumstances. However, recipients must meet several eligibility requirements, co-developed by the Assembly of First Nations and the First Nations Financial Management Board, though the final decision on eligibility is made by Indigenous Services Canada (ISC, 2019b). Indigenous communities must have a financial administration law in place that sets financial and governance practices that will guide financial decision making. They must also have financial statements for the preceding five-year period showing substantial compliance with certain financial standards.

In the past, contribution funding arrangements have created significant challenges for the planning and delivery of appropriate and equitable health programs and services in many Indigenous communities. As noted by the Assembly of First Nations (2017), “[p]rograms are often siloed, informed by Eurocentric ideologies and urban-centric evidence, chronically underfunded, and often do not meet the needs of communities” (p. 6). Indigenous communities have often not been involved in decisions about how the resources can be spent, preventing them from reallocating funds to respond to emerging priorities. Moreover, accountability for how the funds were spent tended to be one-way only – from the communities to the funders (Murphy, 2014; Richardson & Murphy, 2018). The short-term nature of most funding models has not been conducive to long-term planning or sustainability, with time consumed by onerous application and reporting requirements. Funding levels have not reflected Indigenous population growth, the higher costs of providing services in remote regions, or the unique health issues Indigenous Peoples face, resulting in inequitable health programs and services for Indigenous Peoples (Kelly, 2011; Richardson & Murphy,

2018; Smith, 2002). Funding for Indigenous health programs and services is also affected by other variables. First, the funding could be subject to the political will and priorities of the various governments in power (AFN, 2017), or it could be seized by third parties in cases of Band debt (MacIntosh, 2008), leaving communities in the position of having to deliver mandated programs without the necessary funds. Second, funding formulas often only take into account ‘status’ Indians that are ordinarily on reserve (AFN, 2017; Kelly, 2011; Lemchuk-Favel & Jock, 2004a). This leaves some communities with a difficult ethical decision about whether to deny non-status community members residing on reserve access to health services when no alternative health care may be available or provide those services without additional funding, which can constrain community health budgets. Third, funding is often received late in the fiscal year, which can make program delivery difficult (AFN, 2017). While efforts have been made to simplify and streamline the transfer payment process, more sustainable, long-term funding is needed to facilitate long-term programming and ensure programs and services are high quality, comprehensive, holistic, culturally-relevant,

coordinated, and responsive to community needs and priorities (AFN, 2017). Additionally, since many Indigenous people rely on mainstream healthcare services, they must be involved as full and equal partners in decision making related to health systems broadly.

The changing health system landscape in Canada

There is an abundance of evidence that Canada’s health governance and funding structures have contributed to ongoing health disparities for Indigenous Peoples by negatively affecting access to care, promoting inequities, and further entrenching racism within the system (Richardson & Murphy, 2018). Mainstream health systems have not been well suited to meet the needs of Indigenous Peoples as they primarily view Indigenous health through a deficit lens (Henderson, Montesanti, Crowshoe, & Leduc, 2018). Many Indigenous people face barriers in accessing health care, including racism, discrimination, unemployment, and low education (Davy et al., 2016). To address these barriers, there has been a trend, nationally and internationally, towards greater Indigenous self-determination⁷ and self-

⁷ This paper utilizes the United Nations (2007) “Declaration on the Rights of Indigenous Peoples” definition that defines self-determination as a human right and as the ability of Indigenous Peoples to “freely determine their political status and freely pursue their economic, social and cultural development” and exercise “autonomy or self-government in matters relating to their internal and local affairs.” Within the context of this paper, this definition is understood to apply to contexts of “internal self-determination” and Indigenous Peoples’ full participation in decisions that concern them (Mazel, 2016, p. 332).

governance over health systems through various mechanisms that involve the devolution of authority and control over health services delivery from a higher order of government to a lower one (Smith, 2002). In Canada, this devolution of governance responsibility from federal to Indigenous hands has taken a variety of forms, including: the creation of new Indigenous political bodies with broad sets of governance powers established through the settlement of comprehensive land claims; the creation of a new territorial government, Nunavut, to give Inuit greater self-determination in matters that affect them; the establishment of First Nations Health Networks or health authorities with more flexible health governance and funding arrangements; and the partial transfer of specific powers or responsibilities to individual Indigenous communities through the Indian Health Transfer Policy (1989). There are numerous advantages to devolution. It offers Indigenous Peoples more effective control in their spheres of influence, promotes local participation in decision making, enables the development of programs and services that meet local needs, fosters innovation, reduces the number of connections between levels of accountability as jurisdictions are smaller, more closely connects accountability to responsibility and consequences, and provides a way of building regions and communities (Smith,

2002). However, to be effective, devolution processes must be driven and led by Indigenous communities (Population and Public Health Division, 2018; Smith, 2002).

There is broad consensus in academic research and literature that Indigenous-driven models of healthcare are more likely to improve Indigenous health than mainstream or Western models of care because they tend to be more holistic, comprehensive, and culturally appropriate. This body of literature identifies several characteristics considered central to the success of these models. Unlike Western or mainstream models of care that adopt a primarily biomedical approach to care, Indigenous models expand their focus beyond treatment and management of disease to include disease prevention and health promotion, as well as to address social determinants of health (Allen, Hatala, Ijaz, Courchene, & Bushie, 2020; Davy et al., 2016; Harfield et al., 2018). Indigenous models are able to draw from local wisdom, resiliency, and creativity to develop innovative solutions that address the unique needs of communities (Henderson et al., 2018). They prioritize culture and Indigenous ways of knowing and doing by: considering cultural values, customs, and beliefs in program design; defining quality improvement processes by cultural outcomes and indicators; integrating traditional healing and practices;

Funding levels have not reflected Indigenous population growth, the higher costs of providing services in remote regions, or the unique health issues Indigenous Peoples face, resulting in inequitable health programs and services for Indigenous Peoples.

(Kelly, 2011; Richardson & Murphy, 2018; Smith, 2002).



using Indigenous languages and communication styles; employing local Indigenous people; and developing culturally appropriate health promotion strategies and education resources (Allen et al., 2020; Davy et al., 2016; Gibson et al., 2015; Harfield et al., 2018; Walters et al., 2020; Ware, 2013). Indigenous models incorporate a wide range of elements that improve accessibility to services, including flexible hours, outreach, and integrated service delivery models (Davy et al., 2016). Finally, these models support Indigenous Peoples' right to self-determination by emphasizing their ownership, control, and engagement in health services delivery (Harfield et al., 2018).



This latter feature is seen as being essential for overcoming Indigenous disadvantage (Mazel, 2016).

Health system reform to increase Indigenous self-determination over primary care services has been supported primarily through Canada's Health Transfer Policy, which allows communities to increasingly assume control over health programs and services previously provided by the FNIHB. This policy allows most First Nations communities to apply for health transfer, but only Inuit communities in Labrador are eligible (Smith & Lavoie, 2008). Initially, health transfer agreements allowed for the transfer of control to only certain community-based programs, such as Community Health Services, the National Native Alcohol and Drug Abuse Program, Dental Services, Environmental Health, and Hospital Services (AFNHP, 2016). Since the release of the Royal Commission on Aboriginal Peoples' report in 1996, several

actions have been taken to further promote Indigenous self-determination in the planning and management of their own health systems and resources. The right to self-determination became entrenched in both the Canadian Constitution and the United Nations Declaration on the Rights of Indigenous Peoples (2007), and the federal government developed funding streams targeted at activities that facilitated Indigenous-focused primary healthcare reform (AFNHP, 2016). Over the period 2004-2010, the Aboriginal Health Transition Fund and Primary Health Care Transition Fund provided funding for activities that developed or strengthened primary healthcare centres or shifted primary healthcare services to Indigenous communities (Henderson et al., 2018). Collectively, these actions have resulted in approximately 89% of eligible First Nations and Inuit communities assuming some degree of responsibility over the planning and delivery

of community-based health services by 2008 (Henderson et al., 2018; Lavoie & Dwyer, 2016). This included establishing a health department within local governments, integrating some elements of health services within larger First Nations regional entities, and increasingly, adopting models of health services delivery established by federal or provincial legislation and governed by health boards (AFNHP, 2016).

While the Indian Health Transfer Policy (HTP) has fostered greater community control and self-determination over the delivery of healthcare services in most Indigenous communities, wide variation exists across communities and regions in the degree of funding, autonomy, and quality of healthcare services provided (Kelly, 2011; Smith & Lavoie, 2008). This has led to disillusionment with the HTP among some First Nations, who perceive the process as simply an exercise in downloading

responsibility for health services without providing communities with the necessary resources, capacity, or autonomy to be fully self-determining – a perception reinforced over the years by federal budget cuts and the imposition of strict funding caps (AFNHP, 2016; Gabel, DeMaio, & Powell, 2017; Jacklin & Warry, 2004; Lavoie et al., 2010). HTPs have historically included several clauses and conditions that can make it very challenging for communities to exercise self-determination and deliver quality healthcare services, including the exclusion of non-status Indians from funding formulas, limits to the range of programs and services considered eligible for transfer, and the inclusion of a ‘non-enrichment’ clause within health transfer agreements. This clause freezes funding at levels negotiated at the time of transfer, making it challenging for communities to compete for scarce health human resources and leaving the quality of programming vulnerable to

real cost changes (MacIntosh, 2008; Smith & Lavoie, 2008). Currently, mental health services are funded through multiple short-term targeted funding arrangements, which prevent Indigenous communities from developing a long-term, sustainable, and flexible approach to mental health issues that meets their needs (Smith & Lavoie, 2008). The degree of control that Indigenous communities are able to exercise over health services delivery is determined externally by government bureaucrats based on their assessment of whether the community has met certain criteria (e.g., community leadership capacity, good governance structures, demonstrated financial accountability) for acquiring the flexibility needed for self-determination (Howard-Wagner, 2018; Mashford-Pringle, 2016; Mazel, 2016; Ufodike & Okafor, 2017). As noted by Mashford-Pringle (2016), when devolution occurs within the context of pre-existing program and

funding structures, reporting requirements, and partnerships, it leads more to self-administration than it does to self-determination.

Over recent years, several major changes have been made to the HTP that address some of these challenges to self-determination. The range of services eligible for transfer has been expanded in some places to include second- and third-level zone and regional functions, such as coordination, consultation, and staff supervision (AFNHP, 2016). To make health services more equitable for all Canadians, over the past few years the Transfer has adopted a per capita funding model and incorporated a guaranteed escalator of at least 3% per year to account for rising costs (Department of Finance Canada, 2011; Di Matteo, 2019). This change does not address any existing inequities in per capita funding for the provision of healthcare services between Indigenous and non-Indigenous populations or across Indigenous

communities, nor does it address any increased demand for health services that may exist in some Indigenous communities because of greater need or increased population pressures. The nature of the federal government's fiscal relationship with First Nations communities has also been evolving, with its new 10- year grant option for funding core health programs and services. This option provides communities with "greater certainty, greater flexibility, and reduced administrative and reporting burden" (Government of Canada, 2019b, Part 2, para. 4).

Greater Indigenous self-determination over community health services has led to many innovations in services delivery, including the integration of health with other programs and services, such as social services, mental health services, home care, education and non-insured health benefits (AFNHP, 2016). In the context of political, social, infrastructural, and jurisdictional complexity, such collaborative interdisciplinary models of care have been advocated as a means of achieving Indigenous health equity by improving access to a wide range of health and social services in a single location (Henderson et al., 2018). The aim of such interdisciplinary models of care is to "enhance coordination across health organizations, accountability to stakeholders, quality of services,

and linkages between PHC [primary health care] and social services" (Henderson et al., 2018, p. 639). While Australia began introducing such models of care in the early 1970s, with the implementation of Primary Health Networks and Aboriginal Community Controlled Health Systems, Canada has lagged behind, implementing such models in the early 2000s primarily as pilot projects, with funding from the Primary Health Care Transition Fund (Henderson et al., 2018). In 2002, the Romanow Commission recommended the integration of Indigenous health systems as the best model for improving Indigenous health outcomes. The Commission recommended that this integration would best be supported by consolidating and pooling all sources of health funding into a block funding model and allocating this funding to various types of Aboriginal Health Partnerships, varying in size tailored for small communities, urban contexts, and large regional authorities (Lemchuk-Favel, & Jock, 2004a). These partnerships would have a broad mandate, including the design and management of all levels of health services, recruitment, and the development of training strategies within their defined regions. Funding would be based on a per capita funding model, while governance would be based on a not-for-profit structure consisting of a board

of individuals representing the funders and other individuals involved in the partnership. Integrated, interdisciplinary models of care can help improve access to health care and introduce efficiencies of scale; however, they require flexible relationships between and among Indigenous, federal, provincial, and territorial governments (Lemchuk-Favel, & Jock, 2004a).

Yet, despite growing opportunities for Indigenous models of healthcare services, innovations for community-led service delivery continue to face numerous challenges. Many Indigenous communities continue to operate within constrained budgets, which can reduce access to services (Davy et al., 2016). The capacity of Indigenous communities to take advantage of funding available from a patchwork of research and services initiatives can vary widely (Henderson et al., 2018). Many Indigenous communities lack data management capabilities or experience persistent shortages of a range of allied health professionals (Henderson et al., 2018). The context for health policy and health decision making varies across provinces and territories, which may affect the ability of communities to develop innovative and integrated models of service delivery. For example, in Alberta, the majority of reserve communities are funded by the FNIHB to provide public health

interventions rather than primary care, which makes it challenging for some organizations to attract physicians and access clinical resources, especially in remote areas (Henderson et al., 2018). Additionally, highly centralized health decision-making contexts may face additional barriers to the development of some models of Indigenous health governance compared to contexts where decision making is dispersed to regional authorities (Henderson et al., 2018).

While devolution of control over health services and programs is desirable, determining the most effective and relevant Indigenous boundaries and units of devolution can be challenging. As identified by Smith (2002), not all communities or regions have the capacity for self-determination and there may be competing conceptions of ‘self’ in self-governance. In the absence of national policy clarity with respect to self-determination, such challenges can lead to several different structural levels of representation being funded, resulting in self-determination occurring in a haphazard and poorly coordinated manner, fiscal duplication and ineffective governance, as well as duplication of services and program ineffectiveness. Smith argues that given the complicated jurisdictional framework for health policy and services delivery in Canada, jurisdictional

devolution must be built upon identified layers of aggregated responsibility and accountability rather than on a single structural unit. For example, smaller jurisdictions can be aggregated into higher-order regional levels of jurisdictional authority for issues of greater collective scope, while maintaining their autonomous decision making and daily management of services tailored specifically to their local context.

The literature identifies several key considerations in health system transformation. Based on an environmental scan and literature review, interviews with key stakeholders, and case studies of healthcare organizations, Richardson and Murphy (2018) recommend a number of “wise practices” for system- and organization-level changes to policy, funding, and governance structures affecting health outcomes for Indigenous Peoples in Canada. Among their recommended practices for healthcare reform are broad guidelines for policy and systems changes, community engagement, recruitment and retention of Indigenous staff and health care providers, anti-racism and cultural safety education, and Indigenous client care and outcomes tracking. Three interrelated potential areas of action for Canadian health care leaders were identified as critical for closing the Indigenous health gap:

1. realigning authorities, accountabilities, and resources;
2. eliminating racism and increasing cultural safety; and
3. ensuring equitable access to health care.

The Atlantic First Nations Health Partnership (2016) identified a number of considerations for the devolution of First Nations health programs and services in the Atlantic region of Canada, including models that offer minimal disruptions in administration and resource-base, community engagement and participation, strong partnerships at all levels, strong accountability, and opportunities to link to other sectors to have the greatest impact on social determinants of Indigenous health and strengthen First Nations capacity for self-governance. Consideration should be given to concepts of readiness, evidence, cost and sustainability, effectiveness, and political will (AFNHP, 2016). Additionally, Indigenous Peoples must be engaged as equal partners in their own health, wellness, and care to ensure they have access to equitable, holistic and culturally safe health practices at the broader health system level (Alberta Health Services, 2018).





PART III: HEALTH GOVERNANCE STRUCTURES AND FUNDING MODELS IN INDIGENOUS CONTEXTS, GLOBALLY AND NATIONALLY



This section describes various health governance structures and funding models that have supported the provision of health services considered accessible and acceptable to Indigenous clients, and have contributed to some improvement in health outcomes in Indigenous contexts, both internationally and domestically. Specifically, it aims to identify what factors influenced the development and implementation of these governance models; how they measure success; and how Indigenous ways of knowing, the social determinants of health, the wellness continuum, and engagement/partnership are reflected in these models and associated accountability frameworks. Internationally, the examples are drawn from the United States, New Zealand, and Australia, while domestically, the examples are drawn from provincial/territorial, regional, and local contexts.

International

United States

In the United States, the federal government has a well-established policy with respect to self-determination, articulated in the *Indian Self-Determination and Education Assistance Act* of 1975. This policy has resulted in the proliferation of federally recognized tribes exercising self-determination related to health, education, and social services. The policy provides American Indians and Alaska Natives (AI/AN) with an opportunity to exercise autonomy over the planning and delivery of their health systems by allowing them to choose whether they would like to manage specific health programs, have Indian Health Services (IHS) manage them, or use a combination of self-governance delivery systems (Richardson & Murphy, 2018). The choice to have Indian

Health Services manage a tribe's healthcare programs is considered to be a form of self-determination as it is the tribe's sovereign right to make this decision (AFNHP, 2016). Key features of this model include: recognition of autonomy, a voluntary opt-in/opt-out provision, legislative protection, and acknowledgement of cultural diversity, differing levels of community capacity, and the unique health and social needs of tribes. Under this model, healthcare services can potentially be devolved to tribes to assume control over the planning and delivery of health services in proportion to their capacity for self-governance (AFNHP, 2016). This model of self-determination allows tribes to link funding and programming directly to local needs and adapt them to emerging priorities.

One model that has emerged from this American self-governance policy is the Alaska Tribal Health System (ATHS),

which has adopted what the Atlantic First Nations Health Partnership (2016) refers to as a multi-level mosaic model. This system is a network of 40 autonomous tribes and tribal organizations comprising the entire Alaska Native healthcare delivery system. The ATHS has assumed almost full control over the design and delivery of health programs, services, and policies from the IHS, with the exception that federal funding must still be accessed through the IHS (AFNHP, 2016). Funding for these services comes from several federal and state sources, including Medicaid, Medicare, and rural sanitation funding. The ATHS provides primary care health services in 178 villages. Since tribal health organizations are the only healthcare providers available in most areas, they serve everyone in the area regardless of race (Alaska Native Health Board [ANHB], n.d.-a). This is an important consideration in rural and remote areas where access to alternative health care may not be available, and funding must reflect this to prevent budgets from stretching thin. The ATHS is governed by a 26-member board, the Alaska Native Health Board, consisting of one elected or selected representative from the Board of Directors or health committees of each Alaska Native regional health organization. This board has adopted consensus-based decision making to identify health issues and set health priorities, allowing it to speak on

behalf of its constituent regional health organizations with a unified voice (AHNB, n.d.-b). This is considered a key strength of this health governance model (AFNHP, 2016). The ATHS has also developed collaborative relationships with organizations interested in AI/AN health care and undertaken state and federal advocacy efforts (ANHB, n.d.-c). The model establishes tribal sovereignty, responsibility, and ownership over health programs and services.

Alaska is the only state in which nearly all (99%) health programs are managed by tribes and Native organizations (ANHB, n.d.-a). Some successes of this model were assessed for the Southcentral Foundation in Anchorage, Alaska. The Southcentral Foundation has adopted the Nuka System of Care, a relationship-based, customer-owned, approach to transforming health care, improving outcomes and reducing costs (Southcentral Foundation, 2019). This approach is based on three core principles:

1. that Alaska Native people are no longer beneficiaries of a government-run system but rather “owners” of their tribally managed health care;
2. that each customer-owner is in control of their health and has a unique story that influences their journey to wellness – the role of care providers is to support them on this journey by fostering

and supporting relationships between the customer-owner, the family, and the provider; and

3. the practice of a holistic whole person care approach is rooted in Alaska Native peoples’ traditions (Southcentral Foundation, 2019).

The Nuka system offers healthcare organizations “value-based solutions” for data and management, integrated care, behavioural health, workforce development, innovation, and more. Southcentral Foundation has partnered with interested stakeholders to provide comprehensive, holistic, and culturally appropriate primary healthcare services and health promotion programs that address physical, mental, emotional, and spiritual wellness and incorporate traditional elements such as complementary medicine and traditional healing programs. The Southcentral Foundation supports local primary care delivery by village providers through funding, consultation, and regularly scheduled on-site clinical services. To ensure accountability to its members, the Foundation has established goals, objectives, and measures related to its performance in areas such as customer-owner satisfaction, commitment to quality, improved work environments, continued improvement of systems and processes, increased Alaska Native employment in the health

sector, as well as progress on health outcomes across a range of indicators, reporting on these on an annual basis (Southcentral Foundation, 2016). Some significant improvements have been seen in terms of health care accessibility and health outcomes. Since 1996, there has been a significant increase in the proportion of its members with a designated care provider (from 35% to 95%), wait times for routine appointments have decreased from four weeks to one day (in most cases), the rate of childhood immunizations has increased by 25%, and the score on some key health status indicators has been 75% or better (Richardson & Murphy, 2018).

Another model is the Papa Ola Lōkahi model in Hawai'i, established in 1988 after passage of the Native Hawai'ian Healthcare Improvement Act (NHHCIA) as a community-based/community-placed non-profit consortium to administer the Act and raise the health status of Native Hawai'ians in relation to the non-Native population (Halabi, 2018; Mokuau et al., 2016). The organization aims to address health disparities by being involved in policy-making, research, the collection of data and information, the development and implementation of programs and initiatives, the protection and perpetuation of traditional Hawai'ian healing practices, the development of the health workforce; and advocacy work

on behalf of Native Hawai'ians (Halabi, 2019; Papa Ola Lokahi, 2019). Papa Ola Lōkahi has established five culturally appropriate Native Hawai'ian Health Care systems, situated on six islands, which provide a range of health and social services, including comprehensive disease prevention, health promotion, and primary care services. Papa Ola Lōkahi continues to serve as a clearinghouse for the collection and maintenance of data associated with the health status of Native Hawai'ians (Congress of the United States of America, 2001). It has also developed a Native Hawai'ian Health Scholarship Program to build a Native Hawai'ian health workforce and completed a Native Hawai'ian Health Master Plan, involving 50 community and clinical partners working across disciplines and sectors to achieve a shared vision for improving Native Hawai'ian health and well-being (Mokuau et al., 2016). The NHHCIA legislation requires the federal government to consult with Papa Ola Lōkahi on matters pertaining to Hawai'ian health, a relationship that the organization also has with the State of Hawai'i, allowing it to represent the voice of Native Hawai'ians in health matters at both federal and state levels. Papa Ola Lōkahi is governed by a Board of Directors consisting of Native Hawai'ians and is funded primarily by a federal government service grant, with a requirement to

submit an annual report on the use of funds. Additionally, the organization has authority to seek out strategic partnerships with the state government and other stakeholders.

Since 1990, Native Hawai'ians have seen improved health outcomes, manifested in higher rates of life expectancy, lower rates of infant mortality, and increased preventative screenings (Halabi, 2019; Wu, et al. 2017). Facilitators of effective health governance identified in this model have been a well funded initial fact-finding mission, broad stakeholder inclusion, and tailored federal law. However, the transferability of this model of health governance to other contexts may be limited by the fact that Papa Ola Lōkahi operates within clearly distinct boundaries and does not have to contend with the territorial integrity and interests of neighbouring states (Halabi, 2019).

Australia

During the 1970s, Australia undertook a series of primary healthcare reforms. They pioneered comprehensive primary health care with the establishment of Aboriginal Community Controlled Health Services (ACCHSs). Comprehensive primary health care is an approach to health care and health promotion grounded in a social view of

health, community participation, equity, and action on social determinants of health (Freeman et al., 2014, 2016, 2019, 2020). Unlike primary health care, which takes a selective approach that focuses on interventions targeted at specific diseases or front line medical care, comprehensive primary health care emphasizes accessible services and strategies that promote health and prevent disease generally (Freeman et al., 2019; Harfield et al., Mazel, 2016). This can include a diverse range of services, such as: social work, speech pathology, occupational therapy, health education, violence prevention and intervention initiatives, parenting programs, psychologists, peer support programs, child and material health programs and services, men's and women's wellness checks, rehabilitation programs, disability services, treatment, and consultation and referrals. Comprehensive primary health care acknowledges that social, economic, and cultural factors influence people's health, and that health interventions must address social and contextual factors such as economics, social policies, and politics. ACCHSs provide for Indigenous leadership and inclusion in the delivery of community-based health services in ways that help strengthen community resilience and provide culturally appropriate and comprehensive care (Henderson et al., 2018). Both state and federal governments provide

funding for these Indigenous-specific primary healthcare services to ensure that Aboriginal and Torres Strait Islander people have access to such services in a single location, including prevention, diagnosis, treatment, and referral. However, funding arrangements are complex, uncertain, and fragmented, with short-term contractual funding that is proposal-driven and has high administrative costs (Donato & Segal, 2013; Mazel, 2016). Additionally, like Canada, fragmented jurisdictional responsibilities ensure the organizations are not formally coordinated with mainstream primary healthcare services (Donato & Segal, 2013).

Approximately 150 ACCHSs exist in Australia, ranging from large comprehensive primary care centres to small clinics and outreach services in remote communities (Reeve et al., 2015). These organizations are seen as an example of Indigenous self-determination in practice as they are non-governmental health organizations that are owned, run, and overseen by Aboriginal and Torres Strait Islander people. They are governed by community-based boards of directors, elected by members of the health service (Coombs, 2018). Most ACCHSs with a governing committee or board (86%) had governing bodies that were 100% Indigenous, and more than half of the FTE staff of ACCHSs were Aboriginal or

Torres Strait Islander (NACCHO, 2016). The National Aboriginal Community Controlled Health Organization (NACCHO), consisting of elected members of associated ACCHSs, serves as an umbrella organization that maintains the network of ACCHSs around Australia and works to shape national reform of Indigenous health, promote and support best practice models of culturally appropriate and comprehensive primary health care, and promote research to build evidence informed practice (Mazel, 2016).

ACCHSs are reflective of their local context, each varying in size and breadth, and each differing with respect to the ways in which a biomedical clinical paradigm is integrated within a holistic framework (Mazel, 2016). They serve a clientele that includes both Indigenous and non-Indigenous populations. A 2016 report card on ACCHSs indicated that 81% of the 240,299 clients attending the 137 ACCHSs were Aboriginal or Torres Strait Islander, while 17% were non-Indigenous (NACCHO, 2016). Most ACCHSs have mechanisms to ensure continuity of care for patients in hospitals, such as relationships with Aboriginal Liaison Officers and well-coordinated discharge plans for Indigenous patients. Most ACCHSs provide access to a wide range of specialist services, including cardiologists, renal specialists, ophthalmologists,

paediatricians, psychiatrists, diabetes specialists, and allied health services, among others (Mazel, 2016; NACCHO, 2016). Many provide social, preventative, and special needs programmes, education and training, and all are involved in advocacy work (Mazel, 2016). Nevertheless, gaps in health services have been identified, including lack of mental health/social and emotional well-being services, reported by 62% of ACCHSs, and youth services, reported by 56% of ACCHSs (NACCHO, 2016).

ACCHSs provide high-quality, trusted, clinically accredited, culturally appropriate, and holistic and comprehensive community-controlled health services (NACCHO, n.d.). Over time, they have improved their capacity to collect and use health data, track performance, and monitor the health status of their clients (Mazel, 2016). This has largely been spurred by the Australian Government's policy commitment to continuous quality improvement (CQI) processes in Indigenous health services, demonstrated through a requirement for CQI in funding arrangements for health services provision for Indigenous Peoples, as well as the development of a national set of key performance indicators (nKPI) in 2012-13 (Gardner et al., 2018; Sibthorpe, Gardner, & McAullay, 2016). As a result, CQI has been taken up widely across Indigenous primary healthcare

settings. Several frameworks and measures have been developed to evaluate performance related to system access, quality, and health outcomes. These frameworks utilize a wide range of indicators, including antenatal care, immunizations, smoking, alcohol consumption, Type 1 and Type 2 diabetes, cardiovascular disease, rheumatic heart disease, child health, mental health, youth health, child development, otitis media, sexually transmitted disease, and cervical screening (Gunaratnam et al., 2019; Katzenellenbogen et al., 2019; McCalman et al., 2018; Sibthorpe et al., 2016, 2017). Some of the frameworks incorporate culturally appropriate indicators of success based on Indigenous worldviews of holism and connectedness, while others are Western oriented frameworks that measure success using mortality and health status indicators that may not adequately reflect community priorities.

The Ngaa-bi-nya program evaluation framework was developed to guide the evaluation of health and social programs for Aboriginal and Torres Strait Islander people across Australia (Williams, 2018). It encompasses four domains: landscape factors, resources, ways of working, and learnings. Landscape factors include indicators that consider a community's history, environment, and degree of self-determination, as well as factors that influence programs and services or

are related to legislation and policy development. Resources indicators focus on the adequacy of financial, human, and material resources. Indicators related to "ways of working" consider the degree to which holistic caregiving principles are incorporated, the quality of caregiving in practice, the extent of staff support and development, the sustainability of the program, the extent to which accountability, monitoring, and evaluation processes are embedded in the program and resourced, the cultural relevance of data collection tools, and the impact of conducting an evaluation and other quality assurance processes on the program. Finally, Learnings indicators relate to what the community has learned about self-determination and rights with respect to service delivery, Indigenous cultural care and healing, and how the program contributes to the evidence base. This model focuses on identifying progress, relationships, and critical success factors, while avoiding defining programs as either a success or failure.

The One21seventy framework, formerly Audit and Best Practice for Chronic Disease (ABCD) program, consists of eight audit tools covering areas such as child health and vascular and metabolic syndrome. Each tool includes measures covering processes of care and intermediate outcomes (Sibthorpe et al., 2016). More



than 200 Indigenous health services have undertaken quality improvement processes using this framework (Puszka et al., 2015).

The Improvement Foundation's CtG Collaborative developed a comprehensive set of measures related to Aboriginal and Torres Strait Islander people's access to health services and chronic disease as part of the broader Australian Primary Care Collaborative (Sibthorpe et al., 2016). These measures focus primarily on the processes of care and intermediate outcomes, with a small number focusing on organizational structures and processes.

The Queensland Aboriginal and Islander Health Council developed a smaller, more focused, set of primary healthcare measures in several key priority areas, all of which were quantitative and related to client care and outcomes (Sibthorpe et al., 2016). Sibthorpe and colleagues developed a more comprehensive conceptual framework for performance assessment in primary health care based on Donabedian's (1998) classic "structure," "process," and "outcome" model (as cited in Sibthorpe & Gardner, 2007; see also Sibthorpe et al., 2017). This model has four indicator levels: stewardship, organizational structures and processes, processes of care, and intermediate outcomes. Stewardship indicators relate to

policy development, financing and funding, implementation, workforce development, IT infrastructure development and support, and research and development. Indicators related to organizational structures and processes focus on physical equipment and facilities, human resources management, financial management, information systems, needs assessment, staff, service organization and management, processes of care provided, inter-provider agency networks and relationships, community networks and relationships, and performance assessment. Indicators related to processes of care received by patients/clients, families, and communities include risk behaviours, clinical status, activities of daily living, and satisfaction with care.

Recognizing that ACCHSs were faced with heavy contract reporting burdens, the Australian Government developed the National Key Performance Indicators (nKPIs) for the Aboriginal and Torres Strait Islander primary health care framework, which is being used for continuous quality improvement in Indigenous health services (Sibthorpe et al., 2016). As of 2016, the framework included 24 quantitative indicators relating to two of the four levels of indicators identified in Sibthorpe et al.'s (2016, 2017) framework. However, Sibthorpe et al. 2016 argues that while the

nKPIs framework can support quality generally, the availability of only high-level data and the time lag between data reporting periods and when the national government releases its annual report makes the nKPI reporting tool less useful for services at the local level.

The Government of Australia has assessed performance on system access, quality, and health outcomes and reported on these measures every 2-3 years since 2006. In 2016, this evaluation showed that ACCHSs were 23% better at attracting and retaining Aboriginal clients compared to mainstream providers (Department of Health, 2017). Demand for their services increased at a rate of 8% over the two-year period from June 2013–June 2015, and their services were more effective at improving Indigenous health than mainstream healthcare services (NACCHO, n.d.). In the 2016 report card, ACCHS clients showed improvements in several outcome indicators related to diabetes and blood pressure, as well as increased prenatal visits, vaccination rates, and screening rates for a number of health conditions, including diabetes and cancer (NACCHO, 2016). It also showed a decline in the proportion of clients who reported being current cigarette smokers (Department of Health, 2017).

Other evaluation tools have identified a range of improved health outcomes for Indigenous Australians, including improved mental health and well-being of Indigenous youth (Sabbioni et al., 2018), reduced ear infections (McAullay et al., 2017), and increased life expectancy (Donato & Segal, 2013). In addition to tangible health outcomes, Indigenous control over healthcare services has also led to the achievement of more proximal outcomes, including:

- Increased equity and improved access to health services (Kelaheer et al., 2014; Reeve et al., 2015);
- Increased screening, assessments, treatment, and follow-up (McAullay et al., 2017);
- Improved socio-economic outcomes, increased social mobility, increased social capital, and reduced social isolation (Freeman et al., 2019, 2020; Howard-Wagner, 2018; Lawless, Freeman, Bentley, Baum, & Jolley, 2014);
- Increased health enhancing behaviours, improved communication skills and empowerment, and enhanced self-efficacy (Freeman et al., 2019, 2020);
- Decreased rates of preventable conditions and issues, slowed progression of conditions, increased supportive environments for health, increased planned and

managed care, and decreased acute episodic care (Lawless et al., 2014); and

- Reduced alcohol-related harms (Freeman et al., 2019).

Despite CQI being taken up widely in Australia across Indigenous primary healthcare settings, implementing CQI has remained challenging (Gardner et al., 2018; Gunaratnam et al., 2019; McCalman et al., 2018; Sibthorpe et al., 2018). This is due to a range of barriers, including resource constraints (staff turnover/capacity) and lack of organizational support (Cunningham, Ferguson-Hill, Matthews, & Bailie, 2016; Gardner et al., 2018); lack of knowledge and attitudes of staff (Newham, Schierhout, Bailie, & Ward, 2015); challenges in adapting CQI tools for use in specific contexts (McAullay et al., 2017); lack of consistent and reliable information at the local level, and data sharing challenges (McDonald, Bailie, & Morris, 2017; Sibthorpe et al., 2017).

Several studies have assessed the impact of Indigenous community-controlled health organizations in Australia and identified facilitators of successful models. Reeve et al. (2015) evaluated the impact of one partnership between state health services and a community-controlled health organization in Australia on Indigenous access to health services and the factors that were instrumental

to bringing about change. The health organization provided health promotion and early intervention services, as well as acute clinical services. Findings from their research showed a tangible impact on Indigenous health, including improved access to health services, increased utilization of services, and higher quality services. The critical factor identified as enabling health service change was the alignment of a strong local community and health services vision with the goals underpinning state and federal government policies. The partnership further influenced changes in service delivery by making significant structural changes to how, where, and who delivered services by engaging staff and consistently reinforcing the changes made. Morley (2015) undertook a more comprehensive review of available literature to identify factors that facilitated successful Indigenous community-managed programs in Australia. They identified the following factors as contributing to success: facilitating community ownership and control,⁸ embedding culture into programs and services, employing local Indigenous staff, harnessing existing community capacity and its leaders, implementing good governance, establishing

trusted partnerships, keeping the implementation timelines flexible, and using community development approaches. Similar results were found in a systematic review of qualitative evidence on Indigenous Australian client values about primary healthcare provided by Aboriginal Community Controlled Health Organizations (ACCHOs). The review identified three unique and highly valued characteristics of care provided by ACCHOs compared to mainstream providers (Streak Gomersall et al., 2017). First, Indigenous clients regarded ACCHOs as having unique accessibility, with a welcoming environment that includes social, emotional, and physical aspects of supporting cultural safety. Second, ACCHOs are highly valued as providing culturally safe care, by Indigenous staff who are known to clients, understand their needs, and respect the clients' cultures in an environment where they feel comfortable, supported, and like they belong. Third, clients valued that the care provided was responsive to their holistic needs.

Donato and Segal (2013) reviewed Australia's health system reforms and its most ambitious Indigenous health policy initiatives aimed at closing the gap in health inequity to assess

whether attempts to address Indigenous disadvantage were likely to be successful. Through their review of related literature, they found several factors that contributed to the success of initiatives, including: cooperative approaches between Indigenous Peoples and government; community involvement in program design and decision making; good governance at community and government levels; and ongoing government support in the form of human, physical, and financial resources (p. 235). They also learned that respect for local culture, development of partnerships, collaboration and shared leadership, and the development of social capital were key factors that contributed to "what works" in reducing health disparities for Indigenous Peoples. The authors argued Indigenous Peoples in Australia continued to experience poor health outcomes because of the failure of Australia's health reforms to deal with structural problems, such as unifying the funding responsibilities for PHC under a single jurisdiction and addressing historical underfunding of PHC services for Indigenous communities. These structural problems continue to compromise the capacity of health reforms to achieve major system performance

⁸ Community ownership and control can be embedded in community-managed programs through a variety of means, including: establishing local Indigenous management or advisory boards; engaging community in strategic directions over projects; developing formal agreements with partner organizations; and having clients engaged in determining program operational plans, among others (Morley, 2015).

improvements. Funding silos based on professional services and institutional boundaries remained, as did barriers to the development of a collaborative, multidisciplinary, and integrated approach to the delivery of comprehensive PHC services. Further, the absence of a genuine partnership and engagement between Indigenous Peoples and government in formulating the *Closing the Gap* strategy or in broader health system reforms compromised the capacity of current strategies to achieve their goals. Donato and Segal assert that while additional funding may lead to some improvements in Indigenous health, Australia's strategy to close the gap between Indigenous people and the general population likely is unachievable without core structural changes respecting the value of community engagement, ownership, and empowerment, underpinned by a supportive, flexible and comprehensive system of funding. Unifying all funding and policy responsibilities for comprehensive PHC services and incorporating both mainstream and ACCHS sectors within an integrated fund-holding framework would provide a strategic basis for improving health outcomes for Indigenous Peoples in Australia.

In 2015, the Australian government created Primary Health Networks, which substantially affected the ways in which primary healthcare funding

is administered (Coombs, 2018). These networks were established in response to a negative review of their precursor, Medicare Locals, which deemed the locals as bureaucratic and wasteful. The goal of these networks was to improve efficiency, effectiveness, and coordination of health services. The networks function as “third party payers”; they offer funding and support to primary health care providers and control a significant amount of the funding that ACCHSs rely on. Initially, they focused on identifying service gaps but have now moved into a “commissioning phase, which involves ‘co-designing’ and purchasing additional services (including Indigenous-specific services) to fill identified service gaps” (Department of Health and Price Waterhouse Coopers, 2016, as cited in Coombs, 2018, p. S39). This process has resulted in contracting out and privatizing health services. Because PHNs control both the needs-assessment and funding processes, they threaten Indigenous self-determination in health. The power structure and contractual arrangements of PHNs “bind Aboriginal service-providers to the demands of the PHN as purchaser” (Coombs, 2018, p. S40) and leave them excluded from decision making forums on Indigenous health. This ignores the wealth of experience, expertise, and Indigenous cultural knowledge that ACCHSs have, undermines

their authority to identify health priorities and how their funding is spent, and fosters adversarial relationships between Indigenous Peoples and governments. This policy initiative is an example of how governments have excluded Indigenous Peoples from decision-making processes that affect them.

In a study comparing the implementation of Indigenous community control over health care, Lavoie and Dwyer (2016) drew three key lessons for Australia from the Canadian context. In Canada, community control is transferred to pre-existing governance structures. These structures receive funding to develop a community health plan that reflects their priorities and conduct evaluations every five years, the latter of which is considered essential for ensuring continuous improvement. In Australia, Indigenous community control over health care generally involves the development of new non-governmental organizations owned by the local community and incorporated under various national or state laws, which do not receive the same types of resources and supports that Indigenous communities in Canada receive. Implementing Indigenous community control in health care in the Australian context takes time, yet it often occurs within unrealistic timelines, leading to perceptions that Indigenous-controlled health organizations are failures. Lavoie

and Dwyer argue that a long-term vision and resources are needed to support the implementation of Indigenous community control over health care. Part of the challenge in Australia is that there is a more complex mix of funding and regulatory roles between levels of government, leaving no government clearly accountable for improvements in Indigenous health. While constitutional reform may be required to address this issue, other actions could be taken to allocate responsibility for primary healthcare services to the federal government, to clarify roles and responsibilities of federal and state governments, and to harmonize contractual and accountability requirements. Lavoie and Dwyer also highlight Australia's new public management (NPM) contractual approach, which focuses on tendering predefined specific health interventions, as a barrier to implementing Indigenous community control in health care. They argue that in rural and remote Indigenous communities, primary health care requires continuity of care and long-term trust-based relationships between healthcare providers and clients, which are not fostered in NPM approaches. Thus, while Australia has exerted Indigenous control over health policy, implementation remains incomplete (Lavoie & Dwyer, 2016).

New Zealand

New Zealand's healthcare system is similar to Canada's. All residents have free access to public services such as health promotion and disease protection, public hospital care, outpatient services, some community care, and palliative care, while other services, such as primary care, long-term care, and pharmaceuticals, are heavily subsidized by the government (World Health Organization [WHO] & the Ministry of Health, New Zealand, 2012). However, there are some key differences in the Canadian system which may affect the transferability of New Zealand models of health governance and funding to the Canadian context, including the "relationship with the federal government, number of treaties, presence of Aboriginal government and the recognition of the inherent right to self-government," as well as the level of fragmentation of the healthcare system (Lemchuk-Lavel & Jock, 2004a, p. 99). The New Zealand system involves only one health system under federal control, without the additional jurisdictional layer of provincial/territorial governments that is seen in Canada. Māori are guaranteed political representation in Parliament, ensuring they have a greater role in health and decision making at the national level, while Indigenous Peoples in Canada are not. While

Canada has signed a number of treaties, self-government, and comprehensive land claim agreements to recognize and ensure the rights of distinct groups of First Nations, Inuit, and Métis, each with their own terms, governance structures, and funding arrangements. New Zealand has only one treaty that does this – The Treaty of Waitangi, signed in February 1840. This Treaty provides the foundation for the relationship between all Māori and their British colonizers. It promises to protect Māori culture, enabling Māori to live in New Zealand as Māori. It sets out the right to equality before the law. Finally, it recognizes Māori ownership of their lands and resources in exchange for British rule over New Zealand and exclusive rights to purchase Māori lands that they may wish to sell (Government of New Zealand, 2017).

The national government has committed to improving health outcomes for Māori in several ways. It enacted legislation in 2000 which requires Māori to have a formal voice in healthcare planning and decision making through representation on governing boards, and followed this up with the development of He Korowai Oranga, the Māori Health Strategy, which resulted in a proliferation of a diverse range of Māori service providers (AFN, 2017; Goodyear-Smith, & Ashton, 2019; Saulnier, 2014). Additionally, the

national government developed frameworks for strengthening the provision of Rongoā (traditional healing) standards, a process which is led by the national Rongoā body. In each of these initiatives, a comprehensive consultation and approval process ensured that Māori had a voice in all levels of healthcare policy, planning, and decision making.

In New Zealand, Ministry of Health funding for the health sector is administered by District Health Boards (DHBs). DHBs are the largest funders and providers of health services, administering approximately 75% of health funding (WHO & the Ministry of Health, New Zealand, 2012). They are responsible for funding primary care services, public health services, aged care services, and services provided by non-government health providers, such as Māori and Pacific providers (Ministry of Health, New Zealand, n.d.). The roles and responsibilities of DHBs are clearly articulated, with clear mechanisms to “enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services” (WHO & the Ministry of Health, New Zealand, 2012, p. 2).

In 2001, the New Zealand government introduced the Primary Health Care Strategy, which aimed to establish a primary healthcare structure that provides comprehensive coordinated services to enrolled

members and reduces inequalities in health status (Abel, Gibson, Ehau, Tipene Leach, Porou Hauora, 2005). This led to the development of Primary Health Organizations (PHOs). DHBs contract health services delivery to PHOs on a per capita basis, with additional payments for meeting health targets (Goodyear-Smith & Ashton, 2019). In turn, these smaller PHOs are required to “undertake population health initiatives alongside patient-centred primary care, broaden the range of providers and skills used in integrated primary care delivery, improve access to services for disadvantaged populations, and ensure community participation in healthcare service decision-making and governance” (Abel et al., 2005, p. 70). PHOs adopt a holistic approach to primary health care that emphasizes community development and intersectoral collaborations at both individual and population levels. This model of devolved health service delivery means that responsibility and authority for funding and planning occurs at three separate levels – national, regional, and local (WHO & the Ministry of Health, New Zealand, 2012). The national government sets out national minimum service standards in terms of range, accessibility, user charges, quality and safety, and eligibility criteria for a range of health services to which all New Zealanders are entitled. They also establish reporting



requirements to ensure that services are provided in a consistent, equitable, accessible, and high-quality way. DHBs contract health services delivery to small PHOs, and PHOs plan and deliver health services in local communities.

The establishment of PHOs occurred very rapidly, with 91% of the New Zealand population enrolled in 77 PHOs, including over 75% of Māori, by October 2004 (WHO & the Ministry of Health, New Zealand, 2012). In this health governance structure, patients enrol with a PHO and there may be multiple PHOs within the same area, including Māori-specific PHOs. PHOs have responsibility for planning, managing, providing, and purchasing services, including those delivered in communities, such as primary care, home support, and community care services. The majority of these services are delivered by non-government service providers, including Māori and Pacific providers.

The Primary Health Care Strategy resulted in a proliferation of Māori health providers. By 2012, approximately 275 Māori health and disability providers contracted to DHBs were Māori owned, Māori governed, or

delivered their services mostly to Māori (WHO & the Ministry of Health, New Zealand, 2012). These included small providers focusing on one kind of health service, comprehensive providers that provided a mix of personal and public health services, and integrated providers that offered a wide range of health and social services. These services typically adopt a holistic approach, incorporating physical, mental, familial, and spiritual dimensions of health. While they predominantly serve Māori, they can employ both Māori and non-Māori providers and make services available to non-Māori patients (Goodyear-Smith & Ashton, 2019). While PHOs are required to foster engagement with local Māori health providers, enrolment criteria do have the potential to disadvantage Māori health providers that may not have front-line medical services or the capacity to provide a wide range of services without forming partnerships that might jeopardize their autonomy (Abel et al., 2005).

Using a case study of Ngāti Porou Hauora (NPH), Abel et al. (2005) assessed the implementation of PHOs. NPH was established as a not-for-profit charitable organization in 1994, with the aim of providing culturally

appropriate, high-quality, integrated health services at no or low cost to enrolled members in the East Coast region of New Zealand. The organization is owned and managed by a Board of community members. Starting with its first contract to provide residential mental health services in 1995, NPH has expanded to include general practice clinics, the majority of East Coast health services (including the Te Puia Springs Hospital), several urban health clinics, and major health education and health promotion contracts. Just over three-quarters of the enrolled patients are Māori, with the remainder mostly being Pacific Islander. The NPH offers holistic integrated health services, with an emphasis on whānau and hapu⁹ health and disease prevention. Primary healthcare services are offered by multidisciplinary teams of community health workers, including rural health nurses, counsellors, community support service workers, dental health workers, and a physiotherapist.

Over the years, the NPH has encountered several key challenges (Abel et al., 2005). The shift from a focus on clinical care to one on population health introduced challenges related to the collection of population-level health data, including

⁹ Whānau is the Māori word for extended family, while hapu are named divisions of Māori tribes (iwi), which translates closely to 'community.'

prioritizing data collection, analyzing the data, and ensuring it is integrated back into patient care or considered in a population health framework. Additionally, health promotion funding was set at NZ \$2.00 per capita, which was woefully inadequate in the context of complex health issues within the region, even though some initiatives were funded through alternative funding streams. There were also challenges in developing performance evaluation indicators, including determining the appropriateness of such indicators in a Māori context, as some of the dimensions of health that are important to Māori communities were not considered. Since then, work has been undertaken to develop more appropriate frameworks for measuring the effectiveness of health services that take a Māori worldview into account. The Primary Health Care Strategy requires community participation in PHO governance, as well as promotion of partnerships between providers and consumers. However, the interpretation of this requirement has been modified over the years. In the NPH model, partner provider groups are not represented in the NPH Board and must go through their local community Board representative to provide input into governance issues. This enables more community input into primary healthcare service delivery, but creates some tensions in terms

of the provider – consumer partnership. Another challenge was that the PHO per capita funding model for management costs was inadequate to fully cover infrastructure and certain baseline costs. Resolving this issue required lengthy negotiations. Finally, it was expected that replacing a fragmented fee-for-service funding arrangement with capitated funding of an enrolled population would result in a more global contracting arrangement; however, the arrival of new funding streams and contracts for specific projects have complicated the funding process, as each has its own plan, reporting schedule, and financial accounting.

While equity for Māori is embedded in New Zealand policy, putting equity principles into practice in the shaping of funding decisions, program development, implementation, or monitoring has remained a struggle (Sheridan et al., 2011). A series of ongoing reforms occurred in the structures that governed New Zealand’s health system following the election of a centre-right government in 2008. While the previous government prioritized community involvement in governance, local decision making, public health strategies, and reducing inequalities, the new government’s focus was principally on quality improvement, productivity, and service access, as well as increased

efficiency and cost savings. To this end, the Ministry of Health undertook a process of amalgamating PHOs, resulting in a reduction to 32 PHOs of various structures and sizes, with enrollment of approximately 93% of the New Zealand population (Goodyear-Smith & Ashton, 2019). This led to some loss of momentum “in the provision of innovative, accessible, and effective primary health care for high-needs population groups,” as well as an erosion of the commitment to equity in health outcomes (Goodyear-Smith & Ashton, 2019, p. 438). As a result, while Māori have achieved some improvements in health outcomes, including higher life expectancy, lower childhood mortality, near-eradication of infectious diseases, and wider adoption of healthy lifestyles, health system reform has not yet achieved equity of outcomes for all Māori (Health Quality & Safety Commission New Zealand, 2019). Years of spending restraint have also not resolved issues of accessing care for all Māori, as demonstrated in a small 2017 pilot study. This study revealed that 28% of the population, and 38% of Māori, reported not being able to access primary care when required within the past 12 months, due largely to the inability to pay for general practitioner consultations (14%) or schedule an appointment within 24 hours (17%) (Ministry of Health, New Zealand, 2018).

Canadian health models to support Indigenous self-determination

Transferring control over public healthcare services to Indigenous Peoples and communities in Canada has led to improved access to care and health outcomes. It has also increased the development of health models that support Indigenous self-determination. Since each model is tailored to the diverse contexts and unique needs and priorities of communities and regions, they differ substantially. There is only one example of a province-wide devolution model, the First Nations Health Authority (FNHA) in British Columbia (AFNHP, 2016). Ontario has instituted structural reform of the health system for Indigenous Peoples by creating a system of Aboriginal Health Access Centres, which are managed in partnership between the provincial government and Indigenous organizations. Several Indigenous health governance models have been established through self-government agreements. There are also numerous examples of local community models. This section describes various Canadian examples of health models that support Indigenous self-determination.

Provincial models of Indigenous health governance

Only two provinces have implemented large scale structural reforms in Indigenous health governance. BC has undertaken the largest health system transformation, embracing an Indigenous health authority model that encompasses the entire province, while Ontario's health system reform has involved the adoption of a provincial strategy leading to local and regional health governance structures.

British Columbia

Indigenous Health Authorities present an opportunity for a larger scale governance model and funding structure. This model allows eligible individuals to receive the continuum of services, from health clinics to diagnostic laboratories, outpatient care, and hospital services (Lemchuk-Favel & Jock, 2004a). Indigenous Health Authorities have broad responsibility for provincial and federal health programs and services; social programs that are closely connected to the health system, such as adult care, child care, family violence programs, and comparable provincial and territorial systems; and some second and third level management responsibilities.

Implemented in 2013, the First Nations Health Authority in British Columbia is a relatively new model of governance that secures Indigenous control and management of health promotion and disease prevention across BC's regions (Henderson et al., 2018). It was established as a result of a tripartite agreement between the federal and provincial governments and First Nations leadership. This agreement committed the federal and provincial governments to a long-term sustainable funding arrangement through a guarantee of CA \$4.7 billion to the Authority over a 10-year period, with a guaranteed increase in funding of 5.5% annually for five years and a commitment to renegotiate this escalator clause for the second five-year term (AFN, 2017). This level of sustainable funding allows First Nations to engage in long-term planning and develop holistic programs.

The FNHA took over full responsibilities for programs and services that were previously provided by the FNIHB Pacific Office, including primary care, mental health and addictions, and the administration of non-insured health benefits. It also assumed responsibility for coordinating health programs and services with the provincial health ministry and health authorities, and for funding and supporting health services delivery at the local level. Health services

are administered by the main provincial administrative centre, located in Vancouver, BC, and five regional offices.

The FNHA operates within a multi-level shared responsibility governance structure. The FNHA has responsibility for the planning, management, delivery, and funding of health programs and services in 200 First Nations communities across BC (FNHA, n.d.-a). The First Nations Health Council (FNHC) provides political leadership for the implementation of the tripartite commitments, and is composed of 15 representatives from regions across BC (FNHC, 2019). The Council of First Nations Health Directors Association comprises health directors and managers working for First Nations communities. The Council provides technical support and capacity development, and acts as a technical advisory body to the FNHC and FNHA on research, policy, program planning and design, and the implementation of Health Plans (FNHA, n.d.-a). Finally, the Tripartite Committee on First Nations Health coordinates programming and planning efforts between the FNHA, BC regional/provincial health authorities, the BC Ministry of Health, and FNIHB partners (FNHA, n.d.-a). The partnership that governs this health structure is based on reciprocal accountability, rooted in “deep and abiding respect and trust and supported by good

communications,” and is guided by the principles of leading with culture, honouring those who paved the way, maintaining unity and discipline, creating strong relationships, engaging at the appropriate level, and respecting each other’s process (FNHC, BC Ministry of Health, & Health Canada, 2012, p. 8).

Funding for the FNHA consists of three blocks (FNHA, n.d.-b). The first block covers all aspects of primary health care and public health protection, including activities related to health promotion and disease prevention, public health protection, and environmental health. The second block covers supplemental health benefits, including medical transportation, short-term crisis intervention, mental health counselling, dental care, prescription drugs, medical supplies and equipment, vision care, and visiting healthcare professional services. The third block covers health infrastructure support, including health system capacity (e.g., human resources, facilities, and health system transportation activities).

The FNHA model includes some core features identified as central to Indigenous-driven models (FNHA, 2018). Decision making is a shared responsibility between federal and provincial governments and BC First Nations. The FNHA has established strong relationships and partnerships with more

The FNHA has established strong relationships and partnerships with more than 80 stakeholder groups, including federal and provincial departments and agencies, First Nations organizations, academic institutions, and non-profit agencies. This has resulted in several key initiatives to improve health services for First Nations...

than 80 stakeholder groups, including federal and provincial departments and agencies, First Nations organizations, academic institutions, and non-profit agencies. This has resulted in several key initiatives to improve health services for First Nations within the broader health system, including: the signing of the Declaration of Commitment to Cultural Safety and Humility in Health Services in 2016/17 by all health regulatory bodies in BC; the establishment of a partnership with BC Patient Safety and Quality Control to entrench cultural safety and humility as a dimension of quality health services; and the establishment

of mandatory Indigenous cultural safety training for health benefits assessors, mental health providers, and others working in First Nations health. These initiatives have embedded cultural safety into all aspects of care central to Indigenous Peoples in mainstream institutions. Several regions have completed Regional Wellness Plans and Partnership Accords with regional health authorities to provide increased access to health services.

While the FNHA operates on a provincial scale, local community control over the planning and management of health programs and services has been facilitated through flexible contribution agreements provided by the FNHA to individual First Nation communities and their health organizations to support a diverse range of projects that promote community health and well-being. The FNHA has also formed Community Engagement Hubs to encourage natural collaborations, create efficiencies, share resources, and address issues arising for First Nations in mainstream health services (AFNHP, 2016). The FNHA has taken actions to address data gaps by developing their own community surveys to assess housing, food and nutrition, early childhood

development, and health and social services, and working with the Provincial Health Officer¹⁰ to develop a set of culturally appropriate health and wellness indicators. The FNHA has also incorporated actions to address the determinants of health in policy and programs, such as costs associated with having to travel to access health services. Reciprocal accountability has been entrenched as a fundamental aspect of FNHA's health governance structure, with key goals and measures identified to track progress related to the effectiveness of First Nations health governance, impact as a health and wellness partner, and measures related to service quality, among others (FNHA, 2018).

In its review of the FNHA, the Office of the Auditor General of Canada [OAGC] (2015) identified factors that have helped the FNHA overcome structural impediments. These included:

- Sustained commitment of all parties involved in the tripartite arrangement, which allowed a climate of trust and respect to be built as the parties worked to develop a series of accords and agreements that spelled

out how change was to be facilitated, the goals and milestones to be achieved, and the responsibilities of each partner;

- Identification of a single point of contact (the First Nations Leadership Council, consisting of representatives from the three First Nations political organizations in BC) to represent all First Nations in the province and present a unified voice and approach in the negotiations;
- Recognition of structural impediments to service delivery in the agreement, including the legislative changes that needed to be made, the funding mechanism, and the organizations and structures that would support local capacity for program delivery;
- Long-term sustainable funding to provide certainty over operating budgets and allow for long-term planning, with funding mechanisms to account for rising health care costs; and
- Acknowledgement of the need to support the FNHA with not only program funding but also resources for planning, monitoring, and administration.

¹⁰ The Provincial Health Office works with several Deputy Provincial Health Officers, including an Aboriginal Health Physician Advisor who provides independent advice and support on First Nations and Indigenous health issues and focuses on closing the gap in health outcomes between First Nations and other British Columbians.

This model of health governance has led to a number of key improvements in health services provision in First Nations communities in BC. These include: improved turnout at community immunization clinics, mandatory cultural sensitivity training for staff, expanded access to electronic health services, improved access to health services through remote delivery models, improved access to training programs in remote regions (OAGC, 2015), and decreased service times (Levesque, 2017). An evaluation of the First Nations health governance structure highlighted some key successes, including: successful transfer of FNIHB-BC Region responsibilities to the FNHA; demonstrated reciprocal accountability and collaboration among the three parties to the tripartite agreement; integration of First Nations perspectives on health and wellness throughout BC's health system; creation of flexible funding streams and new service delivery models to improve health system access and quality of services; and modest improvements in one of five indicators related to First Nations life expectancy, age standardized mortality, infant mortality and youth suicide (FNHA, Province of BC, & ISC, 2019).

However, the FNHA is still evolving and has encountered some challenges with respect to communication about roles and responsibilities of the various partners and how to work together as equal partners to advance First Nations health (AFNHP, 2016). It has also identified capacity and institutional challenges within both the FNHA and the mainstream health system that constrain the integration of First Nations perspectives of health and wellness into the health system, including increased demands for FNHA participation in engagement and decision-making processes, ongoing racism within organizational culture, and ingrained policies, practices and beliefs discounting Indigenous ways of knowing (FNHA, Government of BC, & ISC, 2019). Additionally, while the FNHA has established an accountability and governance framework to guide operations and promote transparency and accountability, some gaps have emerged pertaining to conflict of interest, recruitment, personnel security, administrative investigations, financial information and disclosure, and employee relocation, which the FNHA has been working to address (AFNHP, 2016; Levesque, 2017; OAGC, 2015).

The tripartite agreement which established this model of First Nations health governance is set to expire in 2021.

The FNHA model serves as a promising model for other Indigenous communities in Canada and worldwide in their struggle for transformation of health governance and self-determination (O'Neil et al. 2016). However, it may not be automatically transferable to other jurisdictions due to differences in regional contexts, community needs and strengths, and the existence of local treaties¹¹ (Richardson & Murphy, 2018). For example, Richardson and Murphy note that in Alberta, health decision making is more centralized than it is in BC, which may pose some challenges in implementing this type of governance model in that province. Additionally, smaller scale models of health governance may be better suited to meet the unique health needs and cultures of some communities.

Ontario

Large-scale structural reform has also been undertaken in Ontario; however, in this province it has led to more localized bodies of health planning and decision making. In 1994, Ontario

¹¹ Since treaties are signed with distinct Indigenous populations, each treaty will have unique provisions for self-governance, presenting a potential barrier to the development of health governance approaches that span multiple Indigenous jurisdictions.

AHACs are leaders in developing partnerships and integrating services with Indigenous and non-Indigenous health and social service agencies, both inside and outside the health system, to ensure that clients have access to a broad spectrum of services.



initiated a period of structural reform in the health system for Indigenous Peoples by implementing the Aboriginal Health Policy. The policy, developed in broad consultation with First Nations, Inuit, and Métis communities, identified Indigenous community-led primary care as a “key pillar of vision for the future” (Ontario’s Aboriginal Health Access Centres [OAHAC], 2015, p. 7). The policy led to the creation of Aboriginal Health Access Centres (AHACs) which provide health services on- and off-reserve, in urban and rural/northern locations

– including 10 that serve First Nations, eight that serve Métis, and four that serve Inuit. These centres are jointly managed in partnership between the Ontario government and Indigenous organizations. Core funding is received from the Ontario Ministry of Health and Long-Term Care through the vehicle of the Aboriginal Healing and Wellness Strategy. AHACs also partner with other provincial and federal departments and agencies to provide services, including the Ontario Ministry of Children and Youth Services (which provides funding for FASD programs), the Ontario Ministry of Health Promotion (which provides funding for healthy eating and living projects), the Ontario Local Health Integration Networks¹² (LHINs) (which provide funding for mental health projects and Aging at Home programs), the Ontario Aboriginal HIV/AIDS Strategy (which provides funding for HIV/AIDS prevention and care programs), and Health Canada (which provides funding for several on-reserve programs and projects (OAHAC, 2015). Additionally, AHACs are leaders in developing partnerships and integrating services with Indigenous and non-Indigenous health and social service agencies, both inside and outside the health system, to ensure that

clients have access to a broad spectrum of services. This includes partnerships with healing lodges, community health centres, community mental health and addiction programs, community support agencies, sexual and reproductive health organizations, local hospitals, long-term care homes, Native Friendship Centres, shelters and housing authorities, Children’s Aid Societies, local schools, community centres, and resource centres, among others (OAHAC, 2015).

AHACs are community-led primary healthcare organizations that offer a diverse basket of services and supports. These include high-quality clinical care focused on integrated chronic disease prevention and management, programs that focus on strengthening families and empowering youth, community development initiatives, mental wellness initiatives and addictions counselling, and traditional healing practices (Henderson et al., 2018; OAHAC, 2015). To improve access to health services, no fees are associated with using the programs and services, and they are holistic, culturally appropriate, patient-centred, trauma-informed, and anchored in the strengths of communities. Key features that contribute to

¹² On November 13, 2019, the Government of Ontario announced its plans to better integrate the province’s health care system, which involves transferring five provincial agencies into Ontario Health and clustering the existing 14 LHINs into five interim and transitional geographic regions (West, Central, Toronto, East, and North) (Ministry of Health, Government of Ontario, 2019).

the success of these centres are that services and programs:

- Are grounded in Indigenous understandings of health and well-being;
- Are interdisciplinary, encompassing traditional healers and mainstream health care providers who work collaboratively to provide ‘wrap around’ care;
- Are community-driven, governed by either a community Board of Directors with local constituency positions or by elected First Nations Band Councils;
- Are community-oriented and engage the community “as active participants in shaping health and support services” (p. 9);
- Encourage family participation and support; and
- Incorporate the determinants of health (OAHAC, 2015).

Over the period 1995 to 2005, AHACs experienced significant expansion, contributing to increased access to health services and improved health outcomes for Indigenous clients and their families (OAHAC, 2015). The AHACs now serve more than 93,000 clients and have made positive contributions to a number of preventable health conditions, including tobacco cessation, children’s oral health, and diabetes. Data have shown that these centres

have contributed substantially to lower emergency room visits and improved access to same-day appointments, health services and screening, disease management, and culturally safe health education and promotion (Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016; Lemchuk-Favel & Jock, 2004a).

Because AHACs financially integrate the health and wellness-related programs of Health Canada and Indigenous Services Canada, they have the potential to produce administrative efficiencies (Lemchuk-Favel & Jock, 2004a). However, they have faced several challenges. There have been episodes of jurisdictional discord and diverse relationships between Indigenous communities, organizations, and governments (Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016). AHACs were often excluded from government initiatives made available to non-Indigenous primary healthcare organizations, thus reinforcing health inequities (OAHAC, 2015). As demand for services began outpacing funding levels, waiting lists increased and major barriers arose in the recruitment and retention of staff, leaving AHACs in crisis by 2005 (OAHAC, 2015). In response, the AHAC Network was established to determine the character and scale of the crisis. Following the release of its findings in the report entitled *Wasekun: Enhancing*

Aboriginal Primary Health Care in Ontario, which resulted in increased recognition of the funding shortfall, momentum began to shift and the Government of Ontario began, in 2007, to provide targeted policy and funding support to AHACs for specific services. While the increased funding has prevented the funding gap from widening, major funding inequities remain and infrastructure shortages persist (OAHAC, 2015). In recent years, the Ontario Ministry of Health and Long-term Care has also invited AHACs to play a larger role in the development of provincial health programs and initiatives.

The Ontario Aboriginal Healing and Wellness Strategy has also led to an unprecedented level of formal Indigenous engagement in setting health priorities and allocating resources within Ontario’s regional health governance model of Local Health Integration Networks (LHINs). LHINs are locally based health authorities that are responsible for the administration of public health care services. They are required to engage with local communities in efforts to plan, integrate, and fund local health care to foster improved access to care and patient experiences (Government of Ontario, 2014; Lavoie, 2013). Each LHIN works with an Aboriginal Health Council to set health priorities and allocate resources (AFNHP, 2016). This

process promotes Indigenous self-determination in local planning and decision making, allowing each community to define the degree and nature of their involvement in the planning process.

Summary

Both the BC and Ontario health governance models aim to address jurisdictional challenges related to First Nations living off-reserve and improve access to services by integrating Indigenous approaches to healing and working to recruit and retain Indigenous health professionals (Henderson et al., 2018). Both of these systems have also moved towards establishing goals for closing gaps in health outcomes between Indigenous Peoples and the general population.

Territorial models of health governance

Unlike most First Nation communities south of the 60-degree parallel, FNIHB does not provide primary care funding for First Nations health programming in the territories (AFN, 2017). Instead, the federal government transfers funds for virtually all First Nations health programming to the territorial governments (AFN, 2017). In the Northwest Territories, the territorial government provides health services either directly or through contribution agreements with First Nations

communities. In the Yukon, the majority of First Nations have self-government agreements and have assumed control over the delivery of health services and programs within their respective regions under the terms of those agreements (AFN, 2017). These self-determination arrangements come with an obligation on the part of both federal and territorial governments to ensure that First Nations play a key role in the development and administration of programs and services for First Nations and that accountability for them goes back to the First Nations themselves. The remaining few First Nations without self-government arrangements continue to receive funding for their community-based programs through contribution agreements with the federal government. First Nations in these two territories can also access FNIHB-targeted funding programs for specific health initiatives, regardless of whether or not they have self-determination over their health programming. While self-government provides Yukon First Nations with a formal mechanism for self-determination in health policy, planning, and service delivery, funding for self-governing First Nations is based on ‘status only’ population numbers, excluding all other non-status residents in communities. Moreover, existing funding programs do not take into account the uniquely higher costs of delivering programs and services in northern Canada

(Council of Yukon First Nations, 2010). This can strain resources when First Nations have an ethical duty to provide health programs and services for other community residents because there are no alternative health care options available.

Nunavut is the only territory or province where the Department of Health is responsible not only for planning programs and services, but also for directly delivering them (OAGC, 2017). With more than 84% of the Nunavut population being Inuit (Department of Executive and Intergovernmental Affairs, 2016), the Department incorporates Inuit Qaujimajatuqangit (traditional Inuit knowledge and values) at all levels to ensure that the design and delivery of health and social services are culturally appropriate in Inuit communities (OAGC, 2017). Funding for these programs is provided by the federal government through a health transfer to the territorial government, just as is done with other territorial governments. In Nunavut, community-level input into health care is minimal due to the elimination of regional-level governance structures resulting from the formation of the territory (Healey, 2016). All hospitals and health centres are governed by the Department of Health, without independent layers of oversight and accountability, making it challenging to address local needs (Healey, 2016).

Regional models

There are a number of examples of federal and provincial health governance models and resource integration at the regional level. Some of these have emerged through land claims and self-government agreements that identify the structure of a new government, fiscal arrangement, and relationships between jurisdictions, enabling more innovative programs and service delivery. Others are community-driven initiatives to achieve economies of scale.

The signing of the James Bay and Northern Quebec Agreement in 1978 resulted in the James Bay Cree of Eeyou Istchee territory and the Inuit of Nunavik operating their own health systems under a provincially legislated authority (Lemchuk-Favel & Jock, 2004a). This model of health governance corresponds closely to the vision of the Romanow Commission's 2002 model of integration that recommended consolidating and pooling Indigenous health into a single budget, which would be administered by an Indigenous health partnership that plans and delivers health services for Indigenous Peoples. Under the terms of the self-government agreement, the James Bay Cree and Nunavik Inuit gained autonomy and accountability over their own health systems through block funding transfers from the federal and provincial

governments. Federal funds for health are transferred to the Quebec government, which in turn funds the two regional boards in a similar manner to other provincial regional boards. These health authorities have responsibility for hospitals, community-based nursing stations, and health clinics within their respective territories (AFNHP, 2016).

The James Bay Cree Board of Health and Social Services (CBHSS) is responsible for the administration of both health and social services, including the delivery of provincial services and the management and delivery of a number of federal programs, for all individuals residing within the territory, regardless of First Nation status (AFN, 2017; Henderson et al., 2018). To support these services, the Cree negotiate with the Quebec provincial government for their allocation of the healthcare budget. This model of governance allows them to develop flexible, holistic, and coordinated programs that overcome strict budget siloes (AFN, 2017). Programs are coordinated into three focus areas: 1) a regional healing program that integrates Cree healing traditions, 2) health and social services delivery, and 3) public health, prevention, wellness, and community planning (AFN, 2017). Within the communities, a primary healthcare model was developed

to avoid fragmentation, promote cultural values, and ensure accessible, continuous, holistic, integrated, patient-centred, and efficient care (Henderson et al., 2018). The CBHSS is governed by a Board of Directors consisting of a Chair elected by the population of all Cree communities, an Executive Director, nine community representatives elected by their respective Cree communities, one representative elected from and by members of the clinical staff, and one representative elected from and by members of the non-clinical staff (CBHSS, 2012). The long-term existence of this model, and regular surveillance and performance evaluation since 1970, has enabled a longitudinal assessment of health status and health determinants, using both traditional health and culturally-specific indicators (see for example, Torrie, Bobet, Kishchuk, & Webster, 2005). This model has contributed to significant improvements in the delivery and accessibility of primary health care and patient outcomes, including in the recruitment and support of medical staff, reduced costs of medications, provision of a corridor of care to larger centres, integration of health and social services, and effective vaccination campaigns (Henderson et al., 2018).

The Inuit of Nunavik receive their health and social services from the Nunavik

Regional Board of Health and Social Services (NRBHSS). Headquartered in Kuujuaq, the NRBHSS is governed by a Board of Directors comprised of 20 members, including appointed representatives of each of the northern villages and institutions within the territory, a regional councillor appointed by the Board of Directors of the Kativik Regional Government, and an Executive Director of the regional board (NRBHSS, 2020a). Each member, with the exception of the Executive Director, serves a three-year term, or until he/she has been replaced or reappointed. The NRBHSS is funded using the same mechanism as the CBHSS.

The NRBHSS operates two health centres which serve 14 Inuit communities – the Inuulitsivik Health Centre in Hudson Bay and the Ungava Tulattavik Health Centre in Ungava Bay. The NRBHSS provides access to: some screening, medical imaging, diagnostic, and treatment services; some affiliated health services, such as pharmacy, dentistry, physical rehabilitation, midwifery, and palliative care; and some specialized medical services through visiting specialists, including dental surgery, gynecology, orthodontics, psychiatry, rheumatology, anesthesia, general surgery, internal medicine maxillofacial surgery, gastroenterology, and pediatrics, among others. The Board is responsible for the

organization, coordination, development, and evaluation of a range of public health promotion, prevention, and protection programs and services, including in the areas of mental health, suicide prevention, addictions, physical health, occupational health, infectious diseases, environmental health, chronic diseases, children, youth and families, and family violence and sexual abuse. Some of these programs and services are offered in partnership with regional organizations (NRBHSS, 2020b). Additionally, the Board provides funding for non-profit community organizations working to improve the social fabric and living conditions of communities, monitors the regional population's state of health, manages the NIHB program, and oversees the recruitment, retention, and development of health and social services human resources. Finally, the Board ensures that Inuit values and practices are included within the mandate of health and social services, that cultural sensitivity is integrated into programs and services, and that services and resources are available in three languages: Inuktitut, English, and French.

The region has had several assessments undertaken of Inuit health status, including the comprehensive Qanuippitaa health survey, conducted in 2004, and health profiles of young

children and their families, youth, adults, and Elders, undertaken in 2015. The 2015 assessments situate health within a holistic social determinants of health framework and use both traditional health and culturally specific health indicators developed collaboratively between Quebec's Institut national de santé publique du Québec and the NRBHSS (NRBHSS, 2015a/b). Some positive indicators include improved access to perinatal services and opportunities to give birth at home through local midwifery programs, increased access to daycares, high levels of self-esteem and cultural pride, preservation of traditional languages, high levels of participation in traditional harvesting activities, and high levels of social capital; though challenges related to high levels of youth distress, drug and alcohol use, unintentional injuries, sexually transmitted diseases, and chronic diseases persist (NRBHSS, 2015a, 2015b).

The Weeneebayko Area Health Authority (WAHA), created in 2010, is a regional, community-focused, health care network which operates hospitals and nursing stations and administers some community health services in remote Cree communities along the James Bay and Hudson Bay coasts of northern Ontario. The WAHA is governed by a Board of Directors composed of two appointed Directors from

each of the six Cree communities in the region and four ex-officio (non-voting) members (WAHA, 2020). It receives funding from both the provincial (for physicians) and federal governments, with both levels of government contributing to the hospital budget (Lemchuk-Favel & Jock, 2004a). The WAHA provides health services using a holistic, integrated approach that incorporates traditional and cultural healing methods into medicine, alongside Western approaches (WAHA, 2019a). It also supports families and communities through health education, advocacy, and Cree language services. WAHA has established a good working relationship with the provincial and federal governments, resulting in increased health budgets, as well as with academic institutions, non-Indigenous health organizations, and other stakeholders (WAHA, 2017). WAHA operates as an acute care model, with core services, including emergency room, obstetrician and hospital services, and primary (outpatient) care in all neighbouring communities. Nevertheless, WAHA notes that at least four more family physicians are needed to provide regular primary care and tackle the management of chronic illnesses such as diabetes, high blood pressure, mental illness, alcoholism, and substance abuse in the territory (WAHA, 2017, p. 3). WAHA has established goals and measures to ensure

and improve the quality and safety of care to patients, with accountability to the First Nations communities provided through annual reports. In its most recent evaluation, the WAHA reported on patient satisfaction, the effectiveness of specific programs, and the quality of care, and highlighted some future areas where baseline indicators for assessment will be developed. The evaluation demonstrated that the majority of patients were satisfied with the services they received in emergency rooms, and the vast majority were satisfied with inpatient services and information received by patients (WAHA, 2019b).

The Nisga'a Valley Health Authority (NVHA) in northern British Columbia is another example of self-governance in health established as a result of a self-government agreement. Founded in 1986, the NVHA is responsible for the delivery of community health services in the Nisga'a Valley. NVHA is composed of four health centres located in each of the Nisga'a communities of New Aiyansh, Gitwinksihlkw, Laxgalts'ap, and Gingolx. The NVHA provides primary health clinical services and community health and preventative services for all residents living in the territory regardless of whether they are First Nations, including in the areas of public health, home support and resident care, cultural and community health, and

mental health and wellness. It also has responsibility for the administration of the NIHB program for all Nisga'a citizens. The NVHA takes a holistic, integrated approach to the provision of healthcare programs and services, incorporating traditional practices alongside Western medicine. It has full control over the processes and measures of success in healthcare delivery and is accountable to the Nisga'a people.

The NVHA is governed by a Board of Directors consisting of six members – one from each of the four communities and one non-Nisga'a member – along with an appointed representative from the Nisga'a Lisims Government (NVHA, 2019). The NVHA is obligated to meet requirements related to the development and implementation of “a comprehensive, well-integrated, open, accountable, and financially responsible approach to the delivery of health programs and services” to individuals residing on Nisga'a lands (Nisga'a Lisims Government, 2020, para. 2). It does this by developing five-year health plans outlining program priorities (revised annually), monitoring progress, and reporting to the Nation on goals, outcomes, and health service delivery (NVHA, 2015). It has developed key performance indicators in the areas of Physician Services/Primary Care, Diagnostic Services-Clinical Lab Services, Emergency and

Nursing Services, Public Health (immunizations, prenatal/postnatal program), Home Support and Resident Care, Mental Health and Community Wellness, Non-Insured Health Benefits, and Human Resources. Successes reported in the 2015-2020 Health Plan include: increased immunizations and preventative care, increased access to diagnostic and emergency services, increased mental health referrals, increased number of child and youth clients committed to the substance abuse treatment centre, increased client encounters with dental services, reduced drug costs, reduced costs for patient travel, and increased number of employees in support of health services (NVHA, 2015).

The Department of Health and Social Development (DHSD) of the Nunatsiavut Government, formerly the Labrador Inuit Health Commission, was also established as a result of a self-government agreement between the Inuit of the northern region of Labrador, the federal government, and the Newfoundland provincial government. The DHSD is responsible for the delivery of Inuit-specific health and social programs across the region in accordance with a set of principles. These include: client-centred approaches; practicing and promoting Inuit culture and language; promoting the balance between rights and responsibilities; empowerment, independence, self-reliance and

self-worth; collaboration and partnerships; accountability to clients and stakeholders; consultation with others to share knowledge and exchange information; respect for oneself and others; demonstrating leadership and fostering positive role modelling; and open sharing of information (Nunatsiavut Government, 2019). The DHSD has a regional office in Happy Valley-Goose Bay, which is responsible for oversight, policy, and program development and implementation. It has community offices in North West River, Happy Valley-Goose Bay, Rigolet, Postville, Makkovik, Hopedale, and Nain. Each of these community offices has a team that works closely with Labrador-Grenfell Health to deliver health and social services in Nunatsiavut, which includes a public health nurse, team leader, community health workers, child care workers, and mental health workers. The DHSD has responsibility for FNIHB's community health programs, including those related to injury prevention, addictions, communicable disease control, healthy children initiatives, home and community care, sexual health, healthy lifestyles, and mental wellness. It is also responsible for the administration of the NIHB Program (Nunatsiavut Government, 2019) and the Province of Newfoundland and Labrador's community and public health services (Lemchuk-Favel & Jock, 2004a).

Nishnawbe Aski Nation has also recently entered into a charter agreement with the federal and Ontario ministries of health that would see the health system transformed into a community planned and delivered system (Richardson & Murphy, 2018). This agreement involves a tripartite arrangement between the federal and Ontario provincial governments and the Nishnawbe Aski Nation to deliver health programs and services to the 49 First Nations communities in the territory, using a model that will incorporate some of the characteristics of BC's FNHA (Palmer et al., 2017).

Small and isolated communities often lack the capacity to implement large-scale changes in the design and delivery of primary health care. Leveraging resources from groups of neighbouring Indigenous communities within a region can help address this challenge. The Tui'kn Partnership, involving five Mi'kmaq reserve communities in Cape Breton, Nova Scotia, is collaborating with district health authorities, the Nova Scotia Department of Health and Wellness, Health Canada, and other partners to achieve equitable health status and outcomes for Mi'kmaq people (AFNHP, 2016). The Partnership emerged from a federal health policy initiative – the Primary Health Care Transition Fund – and is directed by an Executive Management Team consisting

of Health Directors from the five First Nations. The Partnership has made advances in a number of key areas. It has been able to create a model of primary healthcare that is holistic, multidisciplinary, and comprehensive (Tui'kn Partnership, n.d.-a). It has been able to harness the management of community health indicators by developing a Nova Scotia First Nations Client Linkage Registry, which links data from Electronic Patient records at community health centres and the Federal Indian Registry System and shares this information across multiple communities to improve planning and coordination of services (Henderson et al., 2018; Tui'kn Partnership, n.d.-b). In partnership with other stakeholders, it has been successful in developing proposals to plan, fund, and deliver additional programs and services, including: targeted health education programs, expanded telehealth services, health needs assessments, health surveillance management systems, emergency preparedness, early intervention services, maternal child health services, and multidisciplinary team and integrated approaches to mental health and addiction services (Tui'kn Partnership, n.d.-a). As its capacity strengthens, the Partnership is working towards greater community control and responsibility in health governance through a health authority governance structure

and funding model for the five communities. A recently developed five-year strategic plan will enable the Partnership to move towards establishing a more formal structure with authority and accountability to enable local responsibility of health service delivery and evaluation (Health Standards Organization, 2019).

The Atlantic First Nations Health Partnership (AFNHP) is composed of eleven Atlantic First Nations Chiefs representing 32 of 34 Atlantic First Nations and the Regional Executive Officer of the FNIHB region who meet several times per year (AFNHP, 2019). Originally called the Mi'kmaq Maliseet Atlantic Health Board, the Board underwent major reforms and was rebranded as the AFNHP in 2010, with clarification of the scope of decision making and the establishment of several associated processes, including continuous improvement mechanisms (AFNHP, 2019). The Partnership shares decision making in the areas of policy development, planning of programs and services, and use and distribution of new contribution funding related to the programs and services funded by FNIHB, Atlantic Region. Decision making involves four stages. In the first, ideas are gathered from the 34 First Nations communities. In the second, four standing committees, consisting of 10 voting members (one from the

FNIHB and nine from the First Nations) discuss ideas, solicit input from health staff, develop proposals, and make recommendations related to the cluster of FNIHB programs each committee covers. The four committees are: 1) Public Health and Primary Care, 2) Child and Youth, 3) Mental Wellness, and 4) Non-Insured Health Benefits. In the third stage, committee recommendations move to the Health Partnership, consisting of 12 voting members – one from FNIHB and one from each of the 11 First Nations Chiefs. In the final stage, decisions are communicated to the Health Directors and implemented. To ensure transparency and accountability, the FNIHB regularly shares information about expenditures with the Health Partnership, and there are open invitations for provincial health officials and regional leads of other federal departments to attend Health Partnership meetings in order to facilitate linkages to support the advancement of determinants of health and interdependencies among federal, provincial, and First Nations governments in health promotion of service provision (AFNHP, 2019). The Partnership hopes that in the future, as ISC transforms its operations, there will be enhanced opportunities in shared decision making in other sectors, including education, child and family services, economic development, and others.

To ensure that NITHA's health services and programs are grounded in First Nations perspectives and worldviews, its health governance model includes an integral role for Elders at the Board of Chiefs, Executive Council meetings, and working groups.



The Northern Inter-Tribal Health Authority (NITHA), established in 1998, is the only First Nations organization of its kind. It is a partnership that leverages the resources and capacities of four First Nations – the Prince Albert Grand Council, Meadow Lake Tribal Council, Peter Ballantyne Cree Nation, and the Lac La Ronge Indian Band – to assume control over the delivery of “Third Level” services, grounded in First Nations philosophy and principles, to the 33 communities in northern Saskatchewan (NITHA, 2020a). These services are provided to NITHA partners through two units: Community Services and

Public Health. The Community Services Unit provides support for program development, policy and procedure development, capacity building, training and education, partner and community consultations, and advocacy. It also supports the building of linkages in the areas of nursing (home care, primary care, and community health), mental health and addictions, emergency preparedness, nutrition, tobacco control, and eHealth (NITHA, 2020b). The Public Health Unit provides advice and expertise on public health promotion and prevention activities, including disease surveillance, communicable disease control, health status monitoring, epidemiology, health promotion, infection prevention and control, immunization, and research (NITHA, 2020c). The Public Health Unit is guided by a Medical Health Officer who provides public health expertise (NITHA, 2020d). The four partners provide Second Level services, such as program design, implementation and administration, supervision of staff at First and Second Levels, clinical support, consultation, advice and training, while the communities themselves deliver First Level services, or primary health care (NITHA, 2020e).

The NITHA is governed by a Board of Chiefs and Executive Council, with participation of Elders. The Board of Chiefs comprises the four Chiefs

of each of the First Nations Partners. It plays both strategic and operational roles in how NITHA is governed. The Executive Council is composed of four partner Health Directors and the Executive Director (an ex-officio member). At the recommendation of the Board of Chiefs, the Executive Council provides operational and strategic direction on the design, implementation, and monitoring of Third Level services (NITHA, 2014). NITHA decision making is based on consensus. To ensure that NITHA's health services and programs are grounded in First Nations perspectives and worldviews, its health governance model includes an integral role for Elders at the Board of Chiefs, Executive Council meetings, and working groups. Four Elders represent each of the four partners. The NITHA Partnership is grounded in seven key principles:

1. It is empowered by traditional language, culture, values, and knowledge;
2. It works to promote and protect inherent First Nation and treaty rights to health as signatories to Treaty 6;
3. It has representation at the federal and provincial levels;
4. It builds health service models that reflect First Nations values and best practices;
5. It provides professional support, advice, and guidance to its partners;

6. it contributes to capacity building within the First Nations health service system; and
7. it works collaboratively (NITHA, 2019a).

NITHA continues to work in partnership with other external stakeholders, including Health Canada, FNIHB, Saskatchewan’s Ministry of Health and Northern Population Health Branch, the Saskatchewan Registered Nurses’ Association, and provincial educational institutions, among others.

Funding for NITHA is provided by the federal government through a consolidated five-year transfer funding agreement, containing block, set, and flexible funding (NITHA, 2014). This requires NITHA to complete a five-year Operational Health Plan that must be approved by both the Board of Chiefs and the FNIHB. The large proportion of the funding (approximately 68.7%) is through a block funding arrangement (NITHA, 2019b), which supports the administration and delivery of public health and community services (NITHA, 2014). This provides some flexibility in program design and delivery and allows for long-term planning. Set funding accounts for 24.3% of the total funding (NITHA, 2019b) and is targeted toward specific programs and service needs of partner communities, including dental

therapy, northern engagement, eHealth, the Aboriginal Health Human Resources Initiative, nursing education and professional development, the National Aboriginal Youth Suicide Prevention Strategy, the immunization strategy, home care, and the tuberculosis initiative (NITHA, 2014). The remainder of the funding is in the form of flexible funding, which supports some specific programs, such as Home and Community Care (NITHA, 2014). These funding arrangements ensure there is accountability to the partnership communities and the federal government.

NITHA has developed goals and measures of progress in a number of key areas, including service improvement, capacity development, accessible services, and health outcomes. Over the period 2013-14, improvements were seen in some health outcomes, including decreases in reported HIV, Hepatitis C, and Methicillin-resistant Staphylococcus aureus infection (NITHA, 2014).

In 2018, Manitoba Keewatinowi Okimakanak (MKO) signed a memorandum of understanding with the federal government to transform health care for Northern Manitoba First Nations residents. They plan to bring clinical care “closer to home” by establishing a regional First Nations-led health authority, improving

recruitment and retention of health care professionals, and facilitating better coordination with healthcare systems (CTV Winnipeg, 2018; NationTalk, 2019a). The framework for transformation aims to close the gap in health services and improve health outcomes by using a model of patient-centred practice by multidisciplinary teams, blending both traditional medicine and holistic wellness models with Western medicine, and seeking partnerships and leveraging expertise from other health organizations and agencies (MKO, 2018).

Community-based health transfer models

A number of health transfer policy initiatives in Canada have aimed to promote community uptake of federal health services by enhancing coordination across health organizations, accountability with stakeholders, quality of services, and linkages between primary healthcare and social services (AFNHP, 2016). Each has had varying levels of control, flexibility, authority, reporting requirements, and accountability. They often operate within an environment of jurisdictional, administrative, funding, and geographic challenges (AFN, 2017). For example, many First Nations communities continue to rely on short-term, proposal driven, inflexible funding arrangements, with high administrative and

reporting burdens. Others have been able to secure greater autonomy, security, and stability. Generalizing lessons learned from these endeavours to identify foundational principles and processes respecting Indigenous-focused primary health care as a means to effectively scale-up and evaluate health innovations remains challenging. The question remains not as to which policy or model of care may be implemented in a given context, but how to develop best practices for moving beyond specific projects toward integrated initiatives with measurable impacts across Indigenous health systems (Henderson et al. 2018).

One emerging governance model is that of the Sioux Valley Dakota Nation (SVDN), formerly the Oak River Reserve, a First Nations community in southern Manitoba. In 2013, after 21 years of extensive negotiations, the SVDN signed a tripartite agreement with the Government of Canada and the Province of Manitoba, becoming the only First Nation to sign such an agreement with a province in Canada (SVDN, 2016). As per the terms of this Agreement, the SVDN has taken the initiative to not be the subject of *Indian Act* policy,¹³ which has been considered a barrier to

progress in many First Nations communities; instead, they have chosen to be self-governing, based on Dakota traditions under SVDN law (SVDN, 2016; SVDN & Her Majesty the Queen, 2013). The Agreement recognizes the SVDN's sovereign right to "preserve, protect, promote and maintain Sioux Valley Dakota Nation government, language, culture, natural laws, tradition, history and relations with the seven historic Council Fires and with Canada throughout the territory over which Sioux Valley Dakota Nation asserts title" (SVDN & her Majesty the Queen, 2013, p. 2). The Agreement establishes a government-to-government relationship between the SVDN and the federal government, and sets out the roles and responsibilities of each party and the application of federal and provincial laws on SVDN lands. It also allows for the possibility that the SVDN will establish its own process for determining citizenship within the Nation. Both the federal and provincial governments passed legislation to recognize and respect SVDN laws and government in 2014; however, steps are still required to finalize the self-government arrangements.

As a self-governing nation, the SVDN may choose to either delegate jurisdiction of some government functions to other bodies or institutions or retain full control over these functions. They are also free to change these roles at any time (SVDN & her Majesty the Queen, 2013). In this way, the model shares some similarities with that adopted in the United States for American Indian or Alaska Natives. The Governance Agreement reaffirms an ongoing fiscal relationship between the SVDN and Canada, with the funding of the Sioux Valley Dakota Oyate Government and agreed upon programs and services considered a shared responsibility of the two parties. It also sets out that as the SVDN becomes more economically self-sufficient, it will become less reliant on federal funding sources. The SVDN has full discretion to allocate, reallocate, and manage federal funding in accordance with its priorities. It will also be able to continue to access federal and provincial funding for programs and services. The Sioux Valley Dakota Oyate Government will be accountable to both its citizens and the federal government for the expenditure of any federal funds by maintaining "a system of program and financial accountability that is comparable

¹³ The Governance Agreement establishes that the SVDN will be excluded from sections D through F of the *Indian Act*.

to standards of program and financial accountability generally accepted as best practices for governments and institutions in Canada” (SVDN & her Majesty the Queen, 2013, p. 99).

While full governance has not yet been established, the SVDN has a policy of adopting an integrated and collaborative approach that incorporates Dakota culture, values, traditions, and kinship in all departments, including health, justice, policing, education, and social development (SVDN, 2019). In the area of health, the SVDN has jurisdiction in relation to the promotion of public health and the provision of health services, and it may make laws regulating the practice and practitioners of traditional medicine. Health services must be consistent with the principles and program criteria set out in the Canada Health Act (SVDN & her Majesty the Queen, 2013). As a self-government, they also have autonomy in matters relating to the following: children and families, including care, protection, and guardianship of children in need of protection; adoption; conciliation, mediation, and counselling; programs and services to assist families; traditional methods, values, and practices concerning child and family matters; and other domains that affect health and well-being on Dakota lands (Simpson, 2015). In 2018, the SVDN established a new Department of Families,

Dakota Tiwahe Services, that is implementing a new family-centred prevention model, founded upon Dakota principles of sacred teachings that emphasize training and counselling to prevent the apprehension of children from their families (CIRNAC, 2018).

While no analyses appear to have been undertaken with respect to the SVDN’s funding arrangements, governance structures, or health services delivery model, some challenges have been identified in regards to Canada’s current fiscal approach for Indigenous self-government which may be pertinent to the SVDN. Canada’s current fiscal approach involves two components of federal government support (Abele, Ahmad, & Grady, 2019; DeSousa, 2016). The first is the General Expenditure Base, which provides federal funding support for governance, land management, economic development, community development, and treaty implementation (if applicable). This component requires contributions from Indigenous governments through the generation of own-source revenue (OSR) and assumes they will be able to generate adequate OSR. The second involves a Social Transfer of funds that allows Indigenous governments to provide education, social, and health services at a level that considered comparable to

...the SVDN has a policy of adopting an integrated and collaborative approach that incorporates Dakota culture, values, traditions, and kinship in all departments, including health, justice, policing, education, and social development.

(SVDN, 2019).



municipal and provincial services in other jurisdictions (Abele et al., 2019). In a review of fiscal arrangements in the context of Indigenous self-government, DeSousa (2016) noted that the current method of allocating funds through fixed block amounts is inequitable across self-government arrangements, is not responsive to changes in program demands, and does not take into account situations where the Indigenous government’s level of revenues does not match their expenditure responsibilities or the diverse governance capacities and financial management resources Indigenous groups may have. The author argues for the need for national equity, residing within a common Canada-wide framework.



This includes implementing minimum standards in public services; constructing fiscal arrangements on a multilateral policy framework built on “shared principles, priorities and methodologies for determining and allocating fiscal transfers”; basing fiscal arrangements on transparent terms that reflect coordinated federal approaches to ensure equitable outcomes for negotiating Indigenous groups; ensuring fiscal arrangements are attuned to the economic and socio-political circumstances of the Indigenous government and community; and reducing funding disparities between Indigenous and non-Indigenous communities, as well as among Indigenous governments (p. x).

Innovative urban models of health governance

Establishing Indigenous governance structures is more challenging in urban areas due to the greater heterogeneity of urban Indigenous populations – which are composed of First Nations, Inuit, and Métis individuals from across Canada – and the fact that these diverse peoples live off a recognized land base (Morse, 2010). Indigenous Peoples have sought “to fill a critical void in the provision of important services that have been neglected by federal, provincial, territorial and municipal governments” in urban centres by establishing non-profit organizations that aim to address the unique needs,

interests, and aspirations of urban Indigenous residents, while operating in an environment of jurisdictional fragmentation and funding uncertainty (Morse, 2010, p. 2). There are a number of examples of innovative Indigenous-directed health programs and services in urban centres across Canada. These examples are invaluable in connecting urban Indigenous communities, integrating traditional and Western healing practices, and providing a continuum of health services; yet, they face many challenges related to unpredictable non-profit or charity funding (AFN, 2017).

Saskatchewan’s Connected Care Strategy recently showcased a model of care that is uniquely positioned to provide coordinated care, tailored to the needs of First Nations and Métis communities in Regina. With the recent opening of a new Four Directions Community Health Centre, which provides team-based community, primary health, and home care services, Indigenous people with complex medical or social health needs may be connected to other services in the community, such as those that address food security, housing, employment, and other social and financial issues. Community participation was key throughout all stages of the development of the health centre, which helped to create a sense of ownership within the community (NationTalk 2019b).

Anishnawbe Health, incorporated in 1984, is located in Toronto and is part of Ontario's Community Health Centres. These centres are structured similar to the Aboriginal Health Access Centres and offer a wide range of culturally appropriate and holistic services and supports that are grounded in Indigenous cultural beliefs and values. Anishnawbe Health is a fully accredited community health centre that aims to improve the health and well-being of urban Indigenous people by providing traditional healing within a multidisciplinary health care model (Anishnawbe Health Toronto, 2011). The Centre provides medical care and community-based health programs to Indigenous people regardless of ancestry, using a strengths-based approach that focuses on the goal of self-healing. Anishnawbe Health is a registered charity, governed by a Board of Directors. Funding is provided by Ontario's Ministry of Health and Long-Term Care, as well as by a range of Indigenous and non-Indigenous health, education, legal, and social services providers that Anishnawbe Health has formed partnerships with. Like other AHACs, Anishnawbe Health is required by *Ontario's Local Health System Integration Act, 2006* to enter into a service accountability agreement with its Local Health Integration Network, the Toronto Central LHIN. This agreement stipulates that the LHIN will provide funding to Anishawbe

Health to enable it to provide services in accordance with a set of identified terms and conditions. Using the 2014-2017 Agreement as an example, some of these conditions include the following: funding must be spent in accordance with a service plan; unspent funds must be returned to the LHIN at the end of the funding year; funding covers a three-year period; Anishnawbe Health is encouraged to explore service integration opportunities; quarterly and year-end reports must be submitted; and financial reductions can be applied if year-end reports are not submitted on time or information provided is inaccurate or incomplete. The Agreement also addresses ongoing performance improvement in a proactive, collaborative manner, where both parties can identify performance factors (Toronto Central LHIN/ Anishnawbe Health Toronto, 2014).

Established in 1998, the Wabano Centre for Aboriginal Health is an urban AHAC that provides access to quality, holistic, culturally relevant programs and services to urban Indigenous individuals living in Ottawa, including traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services. All services are based on best practices for community health care and incorporate traditional teachings of

Indigenous Peoples (Wabano Centre, n.d.). The Centre works in partnership with other health care and social services, youth groups, mental health organizations, and other partners in the Ottawa region, as well as with academic and other stakeholders, to address urban Indigenous health challenges. It is governed as a charitable organization, with a volunteer Board of Directors. As an AHAC, it receives funding from government sources (91%), particularly the Ontario provincial government, as well as through fundraising initiatives and endowments (9%) (Ottawa Business Journal, 2019).

The Vancouver Native Health Society (VNHS) was established in 1991 as a not-for-profit organization to address the lack of culturally appropriate health services for urban Indigenous people in Vancouver. The Society's mission is to improve and sustain the mental, physical, emotional, and spiritual health of individuals through accessible, strengths-based, patient-centred, interdisciplinary medical care (VNHS, 2019). The Society offers comprehensive medical, counselling, and social services, informed by Indigenous Knowledge and methods, to address a range of health issues, including substance abuse, mental health, chronic disease, homelessness, and poverty. Services include physician and nursing care, HIV/AIDS support and care, early childhood support

services, vaccinations, daycare, diabetes awareness and education, food issues and support, drug and alcohol counselling, a community kitchen garden, dental care, and support for Indigenous people with cancer (VNHS, 2015). The ability to leverage grants and partnerships is essential to urban Indigenous self-determination in health and social services delivery (Howard-Wagner, 2018). The VNHS collaborates and works in partnership with universities and other agencies to address gaps in health equity and health outcomes for urban residents of the Downtown Eastside, of which approximately 62% self-identify as Indigenous (VNHS, 2015).

The VNHS operates within a complicated and burdensome funding structure that sometimes impedes the creation of, or threatens the sustainability of, programs and services – especially those that go beyond clinical care and address the social determinants of health (VNHS, 2019). The bulk of program funding comes from the BC provincial government and the Vancouver Coastal Health Authority, with additional funding coming from the Public Health Agency of Canada, the Children’s Hospital, the Vancouver Foundation, the YMCA, gaming revenue, and donations from philanthropists. Urban Indigenous health and social services organizations in Canada, such as the VNHS, often face unique challenges when

compared with on-reserve First Nations because of jurisdictional ambiguity (Findlay et al., 2019). Because these organizations often offer services to all Indigenous clients, regardless of status, the federal government is not required to provide them with stable and adequate funding. As a result, they often expend considerable energy competing for multiple funding sources, even to carry out similar projects targeted at First Nations, Inuit, or Métis. What is more, they lack flexibility in how these programs are run because the funding is mandated by government policies (Findlay et al., 2019). This reliance on multiple sources of revenue makes it challenging to address the demands of a growing clientele with services that are equitable to mainstream services and ensure a continuum of care (VNHS, 2015). Having to follow externally established agendas also makes it challenging to offer programs identified as important to improving the quality of life of the organization’s clientele (Findlay et al., 2019; Howard-Wagner, 2018).



PART IV: SYNTHESIS OF KEY FINDINGS



This section synthesizes information from the body of literature identified in this review to answer the five research questions identified in the methodology section. Specifically, it aims to answer the questions:

1. How should governments organize their business to support self-determination for Indigenous Peoples?
2. Which governance models support self-determination for Indigenous Peoples and have shown some success in addressing health inequities that may be transferable to the Canadian context?
3. What were the particular supportive and inhibiting factors, including contexts, which influenced the development and implementation of these successful governance models?
4. How can successful self-determination be measured?
5. How are Indigenous ways of knowing, the social determinants of health, the wellness continuum and engagement/partnership reflected in government governance models and associated accountability frameworks?

How should governments organize their business to support self-determination for Indigenous Peoples?

Like the different health transformation models currently and potentially underway, Indigenous Peoples have diverse histories, cultures, languages, beliefs, and practices, as well as interests, needs, and capacities that influence their capacity for self-determination. No single model of health governance or funding arrangement will work across all Indigenous contexts, though some common guiding principles are shared. Since culturally appropriate health care is best defined by those using it, health programs and services must be designed by and for the communities themselves. Governments have an important role in reducing barriers to care and supporting the process toward self-determination for Indigenous Peoples, in both Indigenous and non-Indigenous health contexts and at all scales, through policies and legislation, funding

arrangements, accountability structures, provision of resources and supports, and collaboration with Indigenous Peoples and communities.

International evidence supports the important role of governments in policy implementation. Both the New Zealand and United States governments have implemented clear policies with respect to Indigenous self-determination, facilitating many examples of successful health governance structures. Clarifying the federal government's policy on self-determination may aid the development of more effective Indigenous health governance structures and fiscal arrangements, and promote a more coordinated approach to self-determination (Smith, 2002). However, a strong, sustained commitment to Indigenous rights and self-determination is required to establish trust-based relationships and build Indigenous governance capacity (George et al., 2019; Henderson et al., 2018; Mazel, 2016). Policymakers must support and encourage self-determination through recognizing Indigenous Peoples'

right to self-determination in policy and ensuring that policy commitments are part of implementation plans for action (George et al., 2019). Indigenous Peoples must also be included as equals in health policy development and decision making in broader health systems to ensure that local and regional Indigenous-driven governance structures are not undermined by practices imposed by higher level, non-Indigenous, health organizations and governments (Halabi, 2019; Mazel, 2016). The example of Australia's Primary Health Networks, which were implemented to provide efficiencies in Australia's Health System, highlights how Indigenous self-determination and autonomy can be undermined when control over how funding dollars are allocated is effectively removed from self-determining Indigenous health organizations (Coombs, 2018).

In Canada, Indigenous self-determination in health has occurred in a haphazard and poorly coordinated manner, resulting in a wide array of governance structures, each with their own funding arrangements and their own key provisions, conditions, and funding amounts (DeSousa, 2016; Smith, 2002). This complex and fragmented jurisdictional and funding framework inhibits Indigenous communities from fully exercising self-determination in health care and developing

culturally appropriate and effective programs and services that respond to their local needs and priorities. There is sufficient evidence, nationally and internationally, that collaborative, multidisciplinary, and integrated models of care have improved Indigenous Peoples' access to a diverse range of health and social services by facilitating the seamless fusion of programs and services at the delivery level and ensuring that Indigenous traditions are considered. Such models of care require coordinated mechanisms to overcome jurisdictional challenges and gaps, yet the patchwork of funding and differing jurisdictional responsibilities makes collaboration challenging between various government departments and sectors. Additional changes may be needed in federal or provincial legislation and policy frameworks to remove jurisdictional barriers to the development of integrated models of governance (Lavoie, 2013; Lemchuk-Favel & Jock, 2004a; Richardson & Murphy, 2018).

The body of literature also provides strong evidence that adequate and sustainable funding is needed to support long-term planning and the development of a full range of high-quality services and culturally appropriate models (AFN, 2017; Howard-Wagner, 2018; Lemchuk-Favel & Jock, 2004a; Mashford-

Pringle, 2016; Mazel, 2016; Smith & Lavoie, 2008; Williams, 2018). Wherever possible, multi-year flexible funding arrangements should be provided to communities. This would free up time they would otherwise spend writing reports and proposals and give communities the flexibility they need to allocate funds to address changing community priorities and needs (Lemchuk-Favel & Jock, 2004a). Funding models should be equitable, based on the number of clients being served and realistic costs. They should take into account population growth, age demographics, inflation, and the higher costs of servicing remote communities that may have unique health issues (Council of Yukon First Nations, 2010; ISC, 2019b; Lemchuk-Favel & Jock, 2004a; MacIntosh, 2008; Smith, 2002). Consolidating and pooling funds into a single funding arrangement and devolving purchasing responsibilities of primary healthcare services to a single fund-holder facilitates local priority setting to align health services with the needs of the population, improves coordination of services across sectors that impact health, and better engages communities (Donato & Segal, 2013; Lemchuk-Favel & Jock, 2004b). As noted by Donato and Segal (2013), "[t]he greater the range of services included in a needs-based funding model, the greater the ability to substitute service programs and professional

boundaries and provide an optimum mix of services in the most cost-efficient manner” (p. 236). Additionally, block or flexible funding arrangements allow for reciprocal accountability to both the funding agencies and the communities (AFNHP, 2016).

Devolution processes must involve appropriate control over policy development and decision making rather than simply being a downloading of responsibilities (AFNHP, 2016). Too often, Indigenous Peoples’ voices are not given equal weight in policy development and program decision making, resulting in programs and services that do not fully address their needs or values. These must be incorporated into the funding and priority setting process (Angell, 2017). Take, for example, the continued barriers that exist in accessing traditional medicine and healing practices, including inadequate recognition of traditional medicine in policies and programs, and insufficient funding to support a “traditional medicine” workforce (Ouellet et al., 2018; Redvers, Marianayagam, & Blodin, 2019). To facilitate the building of alliances, support negotiations and institution-building efforts, and provide incentives for cooperation, it is important that governance institutions be built on Indigenous criteria and models and be accountable to Indigenous communities (AFNHP, 2016).

There is no consensus on the best way to deliver and fund primary healthcare services for Indigenous communities. Communities have different capacities for self-determination (Henderson et al., 2018). While aggregating smaller jurisdictions into higher-order regional levels of jurisdictional authorities can result in more efficient services and economies of scale, these services are not likely to be sustainable without strong governance structures and processes at the community level (Smith, 2002). Accordingly, federal and provincial/territorial governments have a residual role to play after transfer of health governance to Indigenous communities (Smith & Lavoie, 2008). They must provide adequate time and resources to support communities in their efforts to strengthen their capacity to be self-determining (AFNHP, 2016; Lavoie & Dwyer, 2016). This includes providing supports and resources for the following reasons: to help communities develop health plans that reflect their priorities; (Lavoie & Dwyer, 2016; OAGC, 2015); to build leadership, partnerships, and an Indigenous workforce; to develop strong governance and accountability frameworks, with indicators of health care effectiveness that are meaningful to both funders and recipients alike (Donato & Segal, 2013; Lavoie & Dwyer, 2016); to acquire the necessary data resources and infrastructure to administer

Too often, Indigenous Peoples’ voices are not given equal weight in policy development and program decision making, resulting in programs and services that do not fully address their needs or values.



high-quality health and social systems (Smith, 2002); and to foster innovation in Indigenous communities through the development of partnerships and multi-jurisdictional collaboration (Lavoie & Dwyer, 2016). Such innovation can lead to economies of scale and more efficient and effective services provision, but roles and responsibilities of the key actors must be clearly defined (Henderson et al., 2018; Lavoie & Dwyer, 2016; Mitton, Dionne, Masucci, Wong, & Law, 2011; Reeve et al., 2015). The federal government can also support self-determination by making changes to existing funding arrangements to ensure adequate and sustainable funding; consolidate funding arrangements

New Zealand, Australia, and the United States share a common language, history of Indigenous colonization, Indigenous health inequities, health systems, and struggles for Indigenous self-determination in health governance.

across departments and sectors; simplify eligibility criteria and reporting requirements; reframe the contractual relationship as a partnership rather than a funder/recipient relationship; and ensure there is equity across funding arrangements nationally in terms of key provisions, conditions, and funding amounts (DeSousa, 2016; Lavoie & Dwyer, 2016; Smith & Lavoie, 2008).

Provincial/territorial governments can also play a substantial role in the devolution process because they have developed and utilize tools that can be useful in shaping federal policy and resources in ways that lighten financial and bureaucratic burdens, including effective data gathering, planning of health services, and maximizing resources (Halabi, 2019). For example, some provinces/territories, such as Ontario, have developed a framework for incorporating Indigenous community involvement in the planning, design, implementation,

and evaluation of programs and services, regardless of whether these services are provided on- or off-reserve. Through policy and stable financial resources, provincial/territorial governments can also play a role in supporting Indigenous community control over health and social services by working with communities to identify priorities for health services, close programming gaps, and support the development of urban Indigenous health centres (AFN, 2017).

Which governance models support self-determination for Indigenous Peoples and have shown some success in addressing health inequities that may be transferable to the Canadian context?

New Zealand, Australia, and the United States share a common language, history of Indigenous colonization, Indigenous health inequities, health systems, and struggles for Indigenous self-determination in health governance. Their governance models may be transferable to the Canadian context, and they certainly offer lessons for this context.

Indigenous Peoples' struggles for self-determination in Australia,

the United States, and New Zealand have resulted in the development of some health system governance structures and funding models that have shown success in addressing the gaps in health equity between Indigenous Peoples and the general population. Each country has had success in fostering engagement and participation of Indigenous Peoples and communities in health governance, resulting in a wide variety of models of Indigenous control over the design and delivery of health programs and services. Many of these models have developed strong partnerships and collaborations with other stakeholders with an interest in Indigenous health. These systems have helped improve Indigenous people's access to holistic, integrated, coordinated, high-quality, culturally safe health programs and services that incorporate culture throughout all aspects of service delivery and respond to local needs and priorities. However, there remains a gap in knowledge and research related to the direct impacts of Indigenous-driven models on health outcomes.

The strengths of these various international approaches to Indigenous self-determination vary. Both the United States and New Zealand have adopted clear national policies that provide legislative protection for self-determination. Both countries also have some models of

Indigenous health governance that include mechanisms allowing health services to be accessed by non-Indigenous individuals residing within the service area, a feature that is considered essential in rural and remote locations. In the United States, the ability of various Tribes to opt in or out of Indian Health Services delivery allows self-determination to be tailored to differing levels of capacity. Of the three countries, only New Zealand has established a mechanism to ensure that Māori voices and perspectives are included at the highest levels of policy development.

Innovative models of service delivery have been established in each of these three countries, including the Alaska Tribal Health System's Southcentral Foundation in Anchorage, with its Nuka Model of Care, Australia's Aboriginal Community Controlled Health Services, and New Zealand's Primary Health Organizations. Some of the successes of these models are that they have: facilitated community ownership and control; embedded culture in all aspects of care; employed local Indigenous staff; harnessed existing community capacity and leadership; implemented good governance structures and accountability mechanisms; established strong partnerships; kept implementation timelines flexible; used community development approaches; facilitated increased accessibility

of services; provided comprehensive care that is patient-centred, family-oriented, and addresses holistic needs; incorporated treatment and management, prevention, and health promotion; and addressed the social determinants of health (Streak Gomersall et al., 2017; Harfield, et al., 2018; Morley, 2015). However, each has also experienced some common challenges related to Indigenous-driven health governance structures, particularly fragmented jurisdictional and funding arrangements, siloed programs and funding, inadequate funding to meet all needs, and exclusion of Indigenous Peoples from broader decision-making processes in areas that affect them. In reviewing the various models of health governance structures utilized in these international contexts, Saulnier (2014, p. 2) made two recommendations related to health governance structures for Canada. First, particular attention should be paid to the importance of the right to self-identify citizenship as a foundation for both positive relationships with governments and a stronger sense of self-determination. Second, integrated models should be implemented by striking a balance between encouraging self-determination and recognizing and integrating the unique concerns of Indigenous Peoples into broader healthcare programs.

What were the particular supportive and inhibiting factors, including contexts, which influenced the development and implementation of these successful governance models?

While there have been positive reviews on various health governance models, there is general consensus that a model that has been successful in one jurisdiction is not automatically transferrable to other jurisdictions, since regional contexts, community needs and strengths, and the existence of local treaties all play roles in determining the best model for planning, management, service delivery, and funding of Indigenous health programs and services across provinces, territories, and regions (Richardson & Murphy, 2018). However, the literature does highlight some common factors that either support or inhibit the development and implementation of Indigenous health governance models that are considered successful and that contain features considered as best practices in Indigenous health care contexts (Harfield et al., 2018; Henderson et al., 2018).

Supportive factors

A strong factor that supports the development and implementation of Indigenous health governance models is the valuing of a human rights-based approach to Indigenous health by national governments (Mazel, 2016). When national governments tie their role to human rights obligations, they are more likely to demonstrate commitment to self-determination through partnerships, reliable long-term support, and other actions that enable an environment where self-determination can be exercised. This environment includes prioritizing the expression of Indigenous cultural values within a predominantly Western health sector, adopting legislative requirements for Indigenous participation on governing boards, and developing strategies to reduce racism and discrimination within the broader health sector (Ferguson, 2014; Goodyear-Smith & Ashton, 2019; Mazel, 2016; Sabbioni et al., 2018).

Community engagement and strong partnerships are considered in the literature as critical to the success of Indigenous health governance models. Community engagement in the development of governance structures helps establish the legitimacy of those structures in the community (AFNHP, 2016; Halliday & Segal, 2012). Community engagement and

participation in program design and decision making help ensure that programs and services are culturally appropriate and reflective of community needs and priorities (OAHAC, 2015; Aboriginal Health Access Centre/Aboriginal CHC Leadership Circle, 2016; Richardson & Murphy, 2018). When health governance structures are driven and governed by the community, they are accountable for their decisions to their citizens.

There is a fairly strong body of evidence showing that strong partnerships and collaborations at all levels can not only help increase Indigenous Peoples' access to comprehensive, holistic, integrated, and culturally appropriate primary health care services and health promotion programs, but can also produce efficiencies (AFNHP, 2016; Lemchuk-Favel, & Jock, 2004a; MacIntosh, 2008; Richardson & Murphy, 2018; Smith & Lavoie, 2008). In the context of small Indigenous communities, where access to resources (including human resources) and services are constrained by small populations, program linkages with related programs and agencies are critical, as no single agency has the range of resources and expertise needed to solve all problems (Smith, 2002). Because of Canada's fragmented jurisdictional framework for Indigenous health, Indigenous communities are constrained in their ability to develop

partnerships and collaborations. However, when they have greater self-determination in health governance through block funding arrangements and budgetary flexibility –as is the case in BC's First Nations Health Authority – they are better able to engage in innovative cross-sectoral and cross-jurisdictional partnerships and collaborations to enhance service delivery. Comparatively positive outcomes in New Zealand highlight that a constructive working relationship is needed between non-Indigenous governments and Indigenous groups for self-determination to be feasible (Saulnier, 2014). This requires sustained commitment of all parties, good communication processes to build trust, meaningful collaborations, respectful interactions, and allowing Indigenous groups a degree of control over determining how their membership is defined (AFNHP, 2016; Mashford-Pringle, 2016; OAGC, 2015; Saulnier, 2014). Good communication is also critical to both the development and maintenance of agglomerated or collaborative models of Indigenous health governance, and can be facilitated by establishing a mechanism for speaking with a unified voice. Examples include the establishment of the First Nations Leadership Council that led to the development of the FNHA in BC and the consensus-based decision making that was adopted

in both the Alaska Tribal Health Board and NITHA.

Good mechanisms of governance and financial accountability are also key ingredients to the success of Indigenous health systems as they contribute to a sense of Indigenous ownership of health services. This includes strong leadership capacity (Freeman et al., 2019; Henderson et al., 2018; Mashford-Pringle, 2016; Williams, 2018), multi-directional accountability and transparency (AFNHP, 2016; Lemchuk-Favel, 2004a; OAGC, 2015), and shared decision making (Donato & Segal, 2013; FNHA, 2018). It also includes continuous quality improvement processes defined by cultural outcomes and indicators (Lavoie & Dwyer, 2016; Harfield et al., 2018; Richardson & Murphy, 2018), supported by stable and sustainable funding arrangements that are unified and based on realistic expenditures (AFN, 2017).

Models of Indigenous health governance that work well are perceived as having unique aspects that enhance accessibility. They incorporate the social determinants of health in programs and services, and they link with other sectors to ensure these determinants are addressed more broadly (AFNHP, 2016; Lemchuk-Favel & Jock, 2004a; Freeman et al., 2014). They provide services that are grounded in Indigenous beliefs,

values, customs, and perspectives on health and well-being; they incorporate flexibility in when, how, and where services are offered (Harfield et al., 2018); they integrate interdisciplinary models of care, with traditional healers and Western health care providers working collaboratively to provide ‘wrap around’ care; and they encourage family participation and support (OAHAC, 2015; Aboriginal Health Access Centre/ Aboriginal CHC Leadership Circle, 2016). These services are comprehensive, with a focus on health promotion, disease prevention, early detection, disease management, and acute clinical services (Reeve et al., 2015). They also have a culturally appropriate and skilled workforce (Harfield et al., 2018).

The role of treaties, land claims settlements, and self-government agreements in the development and implementation of governance models is somewhat unclear. Historic treaties contained only vague reference to, if at all, the federal government’s responsibility over healthcare for First Nations. For example, Treaty 6 contained a “medicine chest clause,” which could be interpreted in multiple ways, from simply providing each household with a first aid kit to full federal responsibility over health care and supplementary benefits (Team ReconciliAction YEG, 2018). In contrast, modern treaties, self-government

agreements, and comprehensive land claims agreements, such as the Nisga’a and James Bay and Northern Quebec agreements, recognize Indigenous rights to self-determination and typically come with a new fiscal arrangement, developed in collaboration with Indigenous self-governments, “that supports the political, social, economic and cultural development of the Indigenous community” (CIRNAC, 2019, para. 4). In these contexts, funding arrangements provide greater certainty and incorporate greater flexibility for Indigenous communities to set budgets and shift funds to meet community priorities and needs. Moreover, these funding arrangements offer the opportunity for Indigenous communities to engage in long-term planning and budgeting to meet longer-term community objectives (INAC, 2018b). It seems clear that these treaties and agreements have led to the implementation of more innovative models of health governance, with greater autonomy, stronger integration, reciprocal accountability, and more culturally appropriate frameworks for evaluating progress. However, it is not clear whether the existence of an early colonial treaty poses a barrier in the early stages of negotiating Indigenous self-determination in health (Richmond & Cook, 2016).

Inhibiting factors

The factors that inhibit the development and implementation of successful health governance structures relate primarily to jurisdictional and funding fragmentation. The division of, and lack of clarity in, the roles and responsibilities of multiple levels of government can result in a fragmented and uncoordinated health system structure that poses a barrier to the development of coordinated health services (AFNHP, 2016; Donato & Segal, 2013; Lavoie & Dwyer, 2016; Palmer et al., 2017; Rodon, 2014; Saulnier, 2014). Likewise, complex, short-term, uncertain, and fragmented funding arrangements can place a high level of administrative and reporting burden on communities, which can stifle innovation and the development of holistic health programs and services. Chronic underfunding and unrealistic budgets that do not take into account the real costs of delivering health services in geographically remote or isolated locations, the lack of alternative healthcare services available to non-Indigenous populations, the unique health needs of specific populations, population growth, or inflation can seriously constrain Indigenous-driven health systems, leading to greater health inequity (AFN, 2017; AFNHP,

2016; Richardson & Murphy, 2018; Smith, 2002). Continued reliance on government funding for operations and government control over priorities, allocation of finances, targets, and performance indicators can have a detrimental impact on Indigenous self-determination in health, especially in the context of changing political will and wavering commitment to self-determination on the part of new national governments (Howard-Wagner, 2018; Mazel, 2016).

There is also some suggestion that the degree of centralized decision making may pose a barrier to the development of Indigenous health governance models. For example, Henderson et al. (2018) argued that because Alberta's health decision making is quite centralized and not dispersed to the regions, as it is in British Columbia, it may not be possible to transfer the FNHA model to the Alberta context.

Competing conceptions of “self” in “self-governance” may also be a barrier to the development and implementation of Indigenous models of health governance in the context of jurisdictional fragmentation for health policy and services delivery (Smith, 2002). This barrier can result in multiple layers of First Nations jurisdiction receiving funding for similar programs and services,

leading to duplication. While aggregating smaller jurisdictions into higher-order regional levels of jurisdictional authority has the potential to result in more efficient services and economies of scale,¹⁴ the local context will need to be considered as this option may only be feasible where there is a shared context (i.e., language, customs, histories, etc.). Additionally, smaller jurisdictions may want to maintain autonomous decision making and daily management of services within their specific local context (Smith, 2002). Aggregation attempts should never be forced on Indigenous Peoples simply to achieve economies of scale, but rather should be voluntary attempts based on “good governance” principles (Graham, 2003).

Lack of capacity within both Indigenous and mainstream health systems is also a barrier to the development and successful implementation of Indigenous health governance. As is evidenced from BC's FNHA, there is limited capacity, in terms of time, human resources, and funding, within the FNHA to participate in ever-increasing engagement and decision-making processes with various local, regional, and provincial bodies and ensure the inclusion of First Nations perspectives in decision making (FNHA, Government

¹⁴ There is some skepticism that such an action can achieve savings or better service through economies of scale (Graham, 2003).

of BC, & ISC, 2019). Likewise, the mainstream health system also requires capacity building to increase awareness among regional health authority boards and the non-Indigenous health workforce about systemic racism, cultural safety, and cultural humility. There is also a need to recruit and retain Indigenous health professionals to ensure the system is responsive to First Nations needs.

How can successful self-determination be measured?

Participating in quality improvement initiatives is considered a best practice in health governance and a characteristic of Indigenous primary health care service delivery models (Harfield et al., 2018). While there has been a growing body of research on continuous quality improvement (CQI) in the context of Indigenous health services in Australia, this research is less well-developed elsewhere and certainly seems to be in its infancy in Canada. A scoping review exploring the impacts of CQI on service systems, care, and client outcomes in the context of Aboriginal and Torres Strait Islander primary healthcare in Australia identified a dearth of research related to the uptake of CQI in general practice and government clinics, impacts of CQI over

time, impacts on care and client outcomes, economic impacts, or community engagement in CQI activities (Sibthorpe et al., 2018). Most of the research discusses the development of various frameworks and results from baseline assessments.

The existing body of literature on CQI demonstrates a shift from “top-down” developed measures for Indigenous health services, which were not necessarily useful or appropriate for Indigenous contexts, to “bottom up,” community-owned and led approaches that account for local context, including Indigenous Peoples’ historical, policy, organizational, cultural and social landscapes; existing and emerging cultural leadership; and informal caregiving that supports programs (McCalman et al., 2018; Williams, 2018). Such approaches are now recommended as best practice as they are seen to engage community members, foster community ownership, and result in indicators that provide more meaningful information to communities for setting local priorities or addressing local needs (McCalman et al., 2018). There is general agreement that for CQI tools to be useful in Indigenous contexts, programs should be evaluated from Indigenous Peoples’ perspectives (McDonald et al., 2017; Williams, 2018), with accountability not to policymakers, programs, or providers but rather to Indigenous patients/clients,

families, and communities (Sibthorpe & Gardner, 2007; Sibthorpe et al., 2016; 2017). They should also be developed based on agreement between the Indigenous health sector and government about which indicators should be included, the quality of the data, how the data will be interpreted and reported, and what should be done by whom and for what purpose (Sibthorpe, et al., 2016). Evaluation frameworks should be objectives-based; that is, performance should be measured against a defined set of objectives and be flexible to adapt to community needs (Puszka et al., 2015; Sibthorpe & Gardner, 2007; Sibthorpe et al., 2017). Since considerable time and resources are required to determine objectives and conduct evaluations, providing Indigenous communities with additional funding support to undertake these activities will be key to ensuring continuous improvement (Lavoie & Dwyer, 2016).

There is also emerging recognition in this body of literature that evaluation frameworks should go beyond clinical indicators to include developing tools for use in comprehensive primary healthcare services. These tools would help account for social and cultural determinants of health in Indigenous communities, including water, food, household level and

environmental determinants, knowledge and skills, and health promoting behaviours (Freeman et al., 2020; Lawless et al., 2014; McCalman et al., 2018). While most of the existing Australian frameworks focused on indicators related to processes of care and intermediate outcomes, successful self-determination in health governance should involve the development and tracking of Indigenous informed goals and indicators relating to system improvement, service satisfaction, service access, Indigenous employment in the health sector, and health outcomes (Harfield, et al., 2018; Sibthorpe et al., 2016; 2017; Southcentral Foundation, 2016).

There is a substantial body of evidence from these CQI and evaluation processes demonstrating that Indigenous community control is improving access to a range of culturally safe services, including screening, immunization clinics, and health education, as well as facilitating greater adherence to treatment plans (Allen et al., 2020; Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016; Auger et al., 2016; Kelaher et al., 2014; Lemchuk-Favel & Jock, 2004a, 2004b; McAullay et al., 2017; OAGC, 2015). There is weaker, but promising, evidence that suggests Indigenous people are very satisfied with Indigenous community-controlled services (Barnabe, Lockerbie, Erasmus, & Crowshoe, 2017; Irving,

Gwynne, Angell, Tennant, & Blinkhorn, 2016; Lemchuk-Favel, & Jock, 2004b), and that these services are contributing to some improved health outcomes in particular contexts, including:

- Reduced rates of hospitalization for Ambulatory Care Sensitive conditions (Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016; Donato & Segal, 2013; Lavoie et al., 2010; Lavoie et al., 2019);
- Reduced alcohol-related harms (Freeman et al., 2019);
- Reduced emergency room visits (Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016; Lemchuk-Favel & Jock, 2004b);
- Better mental health and well-being of Indigenous youth (Chandler & Lalonde, 2008; Sabbioni et al., 2018);
- Reduced ear infections (McAullay et al., 2017); and
- Increased life expectancy (Donato & Segal, 2013).

There remains a need for more research on the impacts of system level changes in Indigenous primary healthcare on closing the Indigenous health gaps (Halliday & Segal, 2012; Sibthorpe et al., 2018).



How are Indigenous ways of knowing, the social determinants of health, the wellness continuum, and engagement/partnership reflected in governance models and associated accountability frameworks?

Indigenous ways of knowing, the social determinants of health, the wellness continuum, and engagement/partnership are reflected in various ways in governance models and accountability frameworks. Indigenous ways of knowing are reflected in models of care and programs that prioritize Indigenous cultural values, incorporate traditional healing methods and approaches alongside Western biomedical approaches, use Indigenous languages and communication styles, employ local Indigenous people, and draw on the strengths of Indigenous Elders, families, and community members (Allen et al., 2020; Davy et al., 2016; Freeman et al., 2019; Gibson et al., 2015; Harfield et al., 2018; Mazel, 2016; Walters et al., 2020; Ware, 2013). They are also reflected in evaluation processes that are based on Indigenous Peoples' perspectives, adapted

to local contexts to ensure they are meaningful and relevant, and include an emphasis on improvement and relationships as critical success factors (McDonald et al., 2017; Williams, 2018).

Social determinants of health and the wellness continuum are often incorporated in holistic policy frameworks and programs that are based on Indigenous Knowledge of the life cycle, Indigenous concepts of holistic health, and continuity of care (Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016). This involves providing comprehensive and accessible primary health care that focuses on:

- Improving health status through health promotion, disease prevention, treatment, and management of chronic conditions and disability;
- Improving access to services through offering low-cost or no-cost services, assistance with transportation, flexible opening hours, outreach, Telehealth, language translation services, advocacy, referrals, traditional healing services, culturally safe services that are free from racism and discrimination, and other means; and
- Adopting approaches that are trauma-informed, patient-centred, consider the socio-economic context of Indigenous Peoples' lives, and

are anchored in the strengths of communities (Aboriginal Health Access Center/ Aboriginal CHC Leadership Circle, 2016; Davy et al., 2016; Henderson et al., 2018; OAHAC, 2015; Richardson & Murphy, 2018).

Social determinants are often reflected in collaborative, integrated, or interdisciplinary models of care that provide comprehensive services as a means of achieving equity by increasing access to a diverse range of health and social services in a single location (Aboriginal Health Access Center/Aboriginal CHC Leadership Circle, 2016; Auger et al., 2016; Freeman et al., 2014; Harfield et al., 2018; Henderson et al., 2018; Goodyear-Smith & Ashton, 2019; Sabbioni et al., 2018). In these models, patients are empowered to take control of their own health and the role of the care provider is to support them on their journey toward wellness (Richardson & Murphy, 2018; Southcentral Foundation, 2019). Indigenous health governance models reflect social determinants of health by fostering Indigenous leadership, building capacity within the health system and their ability to exercise self-determination, and including Elders in the delivery of community-based health services in ways that help strengthen community resilience (Harfield et al., 2018; Henderson et al., 2018; NITHA, 2014; Papa

Ola Lōkahi, 2018; Sabbioni et al., 2018). Social determinants are also incorporated in the adoption of performance evaluation tools that take into account the local context, including history, the environment, factors that influence programs and services, the degree of self-determination, and factors related to legislation and policy development (Sibthorpe & Gardner, 2007; Williams, 2018).

Community engagement has been identified as central to the success of Indigenous health governance because it ensures Indigenous ownership of and accountability for health services. It is reflected in:

- Citizen engagement in priority setting and policy decision making, both locally and within the broader health system (Fridkin, 2016; Lavoie, 2013);
- The formation of Community Engagement Hubs to encourage natural collaboration across communities (AFNHP, 2016);
- The development of performance goals and measures that are appropriate to the local context (Lemchuk-Favel & Jock, 2004b);
- The participation of Indigenous organizations in regional planning forums (AFNHP, 2016; Kelaher et al., 2015);

- Strategies and approaches that engage patients as partners in their care (Sabbioni et al., 2018); and
- Approaches to care that draw on the wisdom of community members and Elders in care plans and treatment strategies (Sabbioni et al., 2018).

Despite the importance of community engagement to Indigenous health governance, formal mechanisms for community engagement are often lacking in these structures (AFNHP, 2016).

Strong partnerships with other governments, health and social services organizations and agencies, academics, and non-profits are critical to the development of Indigenous community-controlled health services in order to enhance service delivery (AFNHP, 2016; Henderson et al., 2018; Howard-Wagner, 2018; Sabbioni et al., 2018; Smith, 2002).

Partnerships are generally reflected in the development of cross-jurisdictional linkages and agreements with other service providers to: promote integration and establish innovative models of service provision; enhance access to a wider range of services for community members; facilitate the sharing of information, data, and expertise across communities, regions, and organizations; and take advantage of economies of scale (Harfield et al., 2018; MacIntosh, 2008; Mashford-Pringle, 2016; Smith & Lavoie, 2008). Strong partnerships are also reflected in models of shared decision making and accountability processes, such as the First Nations Health Authority in BC, which involves a partnership among federal and provincial governments and First Nations leadership, with shared decision making regarding priorities, the development of goals and indicators of success, and reciprocal accountability processes.



PART V: CONCLUSION



While community control and self-determination have improved the delivery of health care in Indigenous communities, efforts to establish these have not yet been sufficient to close the gap in health disparities between Indigenous and non-Indigenous populations (Kelly, 2011). This is due, in part, to the deeper structural issues Indigenous communities face and the lack of control they have over major determinants of health, such as access to food, water, and housing (Levesque, 2017). Self-determination over health programs and services has led to improved access to health and prevention services for Indigenous people and communities, as well as to some promising improvements in health outcomes, including lower rates of hospitalizations for conditions that are treatable at the community level, improved mental health, and reduced otitis media, among others (AFN, 2017; Sabbioni et al.,

2018; Sibthorpe et al., 2017). However, self-determination requires that communities have the tools and resources they need to deliver high-quality programs and services that address their needs and priorities. The literature highlights the importance of flexible and sustainable funding models, a strong sense of community ownership, strong governance structures and accountability mechanisms, strong partnerships at all levels, and opportunities to link with other sectors to affect the determinants of health and strengthen Indigenous capacity for self-governance (AFNHP, 2016; Lavoie & Dwyer, 2016). These types of arrangements are critical for encouraging innovation in health services delivery. Given the challenges associated with current funding arrangements, capacity must be strengthened within Indigenous communities to enable them to take control over their own programs and services.



Provincial, territorial, and federal governments must work as equal partners with Indigenous Peoples and communities to determine the governance and funding models that will work best in meeting their unique and diverse needs and priorities. All levels of government must be committed to and support, through policy and adequate resources, the development of Indigenous-driven health programs and services, regardless of whether these serve urban Indigenous populations or Indigenous Peoples who have signed self-government agreements.

Within the scope of this literature review, the evidence does not lead us to conclude that there is one particular model of best practice in Indigenous health governance. While one model may be promising, Indigenous Nations across the country are unique and distinct, and therefore need to be creative in designing a control model that works for them. Indigenous communities need to be able to identify their own priorities and address their own unique needs, utilizing approaches that

reflect their own worldviews and community contexts. They must not be expected to transpose an existing healthcare model into their individual and collective contexts. Although most models include partnerships between Indigenous and various levels of non-Indigenous governments, the multi-jurisdictional context of Indigenous Nations in Canada will require Indigenous Services Canada, in partnership with First Nations, Inuit, and Métis Peoples and communities, to be creative in co-designing a control model that works for them, based on underlying Indigenous Knowledges and the unique histories and conditions that contribute to success.

Results of the review found that although there is no one overarching model for successfully devolving federal healthcare services to Indigenous communities, some common features are shared by models of Indigenous health governance, both internationally and domestically, that support Indigenous self-determination and aim to improve health outcomes for Indigenous Peoples.



These include the following:

- Sustained national government commitment to Indigenous rights and self-determination
- Clearly articulated roles and responsibilities between federal, provincial/territorial, and Indigenous governments in health governance
- Scalable self-determination dependent on capacity
- Community engagement and participation in the design and delivery of health programs, services and policies, both locally and within the health system at large
- Health programs and services grounded in Indigenous ways of knowing, worldviews, and perspectives
- Strengths-based holistic approaches to health programs and services
- Citizenship defined by Indigenous communities as a foundation for both positive relationships with governments and a stronger sense of self-determination
- Adequate, sustainable, and flexible funding arrangements that can be linked directly to local needs and adapted to meet emerging priorities, and that can facilitate long-term planning and integrated, multidisciplinary approaches
- Representative Indigenous non-profit governance structure
- Collaborative and shared leadership, based on true partnership
- Harmonized contractual and accountability requirements
- Strong partnerships and collaborations with other stakeholders with an interest in Indigenous health to leverage expertise and service delivery capacity
- Strong two-way relational accountability
- Involvement in data collection/management to inform program design and policy development
- Involvement in workforce development to promote recruitment and retention, as well as a well-trained, culturally sensitive workforce
- Quality assurance processes based on cultural outcomes and indicators, utilizing community owned and led approaches
- Ongoing federal/provincial/territorial government support for Indigenous health governance in the way of human, physical, and financial resources.



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