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Health Reform Monitor

Advancing Indigenous primary health care policy in Alberta, Canada

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ABSTRACT

For Indigenous people worldwide, accessing Primary Health Care (PHC) services responsive to socio-cultural realities is challenging, with institutional inequities in healthcare and jurisdictional barriers encumbering patients, providers, and decision-makers. In the Canadian province of Alberta, appropriate Indigenous health promotion, disease prevention, and primary care health services are needed, though policy reform is hindered by complex networks and competing interests between: federal/provincial funders; reserve/urban contexts; medical/allied health professional priorities; and three Treaty territories each structuring fiduciary responsibilities of the Canadian government.

In 2015, the Truth and Reconciliation Commission (TRC) of Canada released a final report from over six years spent considering impacts of the country's history of Indian residential schools, which for more than a century forcibly removed thousands of children from their families and communities. The TRC directed 94 calls to action to all levels of society, including health systems, to address an historical legacy of cultural assimilationism against Indigenous peoples. To address TRC calls that Indigenous health disparities be recognized as resulting from previous government policies, and to integrate Indigenous leadership and perspectives into health systems, PHC decision-makers, practitioners, and scholars in the province of Alberta brought together stakeholders from across Canada. The gathering detailed here explored Indigenous PHC models from other Canadian provinces to collaboratively build relationships for policy reform and identify opportunities for PHC innovations within Alberta.

1. Introduction: Indigenous primary health care reform in Canada

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

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

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

Additional funding for Indigenous-focused PHC reform came by way of a $200 million CAD Aboriginal Health Transition Fund (AHTF, 2004–2010), the result of government and national Indigenous leader meetings to address health disparities [4]. Though not PHC-specific, the AHTF became another policy foundation supporting transformation of PHC services for Indigenous peoples. Activities developed or strengthened PHC centres, including enhancing health teams for improved support of people with unique needs, such as in mental health. This generated further impetus for innovating HTP arrangements, which since 1989 have led to as much as 89% of eligible First Nation and Inuit communities and tribal councils in Canada assuming some degree of responsibility for planning and delivery of community-based health services [6]. Beyond broad PHCTF aims to enhance coordination across health organizations, accountability to stakeholders, quality of services, and linkages between PHC and social services [8], contextual considerations have long complicated Indigenous-focused initiatives. The challenge remains to generalize lessons learned from such work, to identify foundational principles and processes around Indigenous-focused PHC as means of effectively scaling and evaluating innovations. The question addressed here is not simply to identify what policy or model of care may be implemented in a given context, but to develop best practices for moving beyond the contextual specificity of local projects towards integrated initiatives with measurable impacts across Indigenous health systems, with sound evidence to guide future reforms.

2. PHC reform as key to reconciliation

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

As indicated, Indigenous-driven models for meeting community health care needs have tended to be mobilized in pilot efforts isolated from wider systemic transformations. Notable exceptions include innovations in the provinces of Ontario and British Columbia, where system-level initiatives have sought to fill gaps experienced, for instance, when patients move between jurisdictions, such as from on-reserve services historically administered federally through Health Canada and urban services in the domain of provincial providers. Ontario's ten Aboriginal Health Access Centres (AHACs) provide services in on- and off-reserve, urban, and rural/northern locations, focusing on integrated chronic disease prevention and management, family-focused care, youth empowerment programming, addictions counselling, and the incorporation of traditional healing (https://www.aohc.org/aboriginal-health-access-centres). Meanwhile, British Columbia's First Nations Health Authority (FNHA) took over services previously provided by Health Canada's FNIHB, securing Indigenous control and management of health promotion and disease prevention across regions (http://www.fnha.ca/about/fnha-overview). Achieved in the 1990s and 2013, respectively, both models predate the TRC, though they move their systems towards establishing measurable goals for closing health outcomes gaps (TRC call 19), addressing jurisdictional disputes for people who do not reside on reserves (TRC call 20), integrating Indigenous approaches to healing (TRC calls 21 & 22), and ensuring the recruitment and retention of Indigenous health professionals (TRC call 23).

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

3. Mobilizing stakeholders

The *Innovating Indigenous Primary Care in Alberta* gathering brought together Indigenous leaders, provincial health system leaders, PHC practitioners (i.e., physicians and nurses), and scholars to dream big about what Indigenous PHC should and could look like in the province. Approximately sixty-five (n = 65) Alberta stakeholders gathered to explore how partners could collaborate to move an Indigenous primary health care agenda forward, while engaging the diversity of cultural, geographic, jurisdictional, and Treaty contexts within the province. The size of the invited stakeholder group (i.e., audience members, breakaway session participants) was strategic—large enough to allow discussions among inter-professional groups, and small enough to allow for summative attention to move an agenda forward. A guiding principle affirmed by the convener, the University of Calgary's Department of Family Medicine, was respect for Indigenous self-determination, including Indigenous community decisions on the leadership and service providers to act in their interests. This meant that invitations to the gathering were extended to individuals in the province fulfilling roles as health directors of primarily Indigenous PHC services, medical leads, and those carrying regional or tribal health portfolios. Preparation included consultations with an expert advi-

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