



Towards healthier Indigenous health policies? Navigating the labyrinth for answers

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Abstract

This research is based on two years of community-based participatory research that draws on Indigenous understandings of health policy in five First Nations in Ontario, Canada. While a number of policies have been put in place to increase Indigenous control over community health services, we argue that policies enacted to promote Indigenous self-determination in health care have been counterproductive and detrimental to Indigenous health and wellbeing. Instead, we suggest that Indigenous health policy exists on a continuum and aim to balance the need for including diverse Indigenous groups with comprehensive control from program funding and design to implementation. This poses some difficult questions: How do Indigenous peoples perceive the concept of self-determination, community-controlled health care

and the efforts of the Canadian government to form collaborative arrangements between Indigenous communities, organisations and government? What does an inclusive and comprehensive Indigenous community-controlled health care system look like? The purpose of this article is to explore how Indigenous people and community stakeholders in Canada understand terms such as *self-determination* and *health* and draw conclusions about collaborative efforts between the government and Indigenous communities to support community-controlled health care. It further explores participant narratives and describes their experiences, particularly, the strengths and weaknesses of community-government health policy developments.

Keywords: Indigenous people, North America, health and wellbeing, health care administration, health policy/policy analysis, social equality/inequality, self-determination, qualitative research.

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Introduction

Canada is one of the healthiest countries in the world, however it has one of the greatest disparities in the quality of health care across its population. The 1.4 million Indigenous peoples accounting for 4% of Canada's population are the fastest growing segment of the population.¹ Indicators of economic, social, health and wellbeing among Indigenous peoples living in Canada compare unfavourably with the Canadian population overall (Adelson, 2005; Cooke, Mitrou, Lawrence, Guimond, & Beavon, 2007; Stephens, Porter, Nettleton, & Willis, 2006). Indigenous peoples around the world continue to bear a disproportionate burden of physical and emotional illness (Bartlett, 2003). Historically, they were not only displaced physically from their land through colonisation but also made subject to intensive missionary activity with the establishment of the residential school system, the purpose of which was to assimilate Indigenous Peoples into mainstream Canadian society. These assimilationist activities undermined the social and cultural fabric that is central to Indigenous identity, as they forbade families from sharing the cultural practices that tied Indigenous Peoples to their traditional environments, including water, plants and animals (Richmond & Ross, 2009).

Currently, Indigenous peoples in Canada continue to experience the health effects related to colonial and post-colonial legacies (Adelson, 2005). These legacies undermined Indigenous people's cultures, languages and social structures and resulted in widespread marginalisation (Anderson, Smylie, Anderson, Sinclair, & Crengle, 2006). As a result, Indigenous peoples face higher rates of injury and accidental death than the non-Indigenous population and continue to report being at an increased risk of infectious disease. Further, cardiovascular disease, cancer, metabolic disorders (diabetes) and respiratory and digestive disorders, along with other chronic diseases are significant problems in Indigenous illness and death (Richmond & Ross, 2009). These inequalities are

the result of disparities among the social determinants of health (SDOH), or the social and physical environments, structures and institutions that affect the health of the Indigenous population in Canada (Reading & Wien, 2010). The SDOH affected include socioeconomic status, housing conditions, employment, education level, exposure to environmental hazards, access to healthcare services, and ultimately affect the health-related behaviours and attitudes of individuals and communities (Reading & Wien, 2010; Richmond & Ross, 2009). These determinants of Indigenous health are interactive and are affected by unequal power relations stemming from a long history of colonialism, which affects dominant Canadian ideologies, policies and decision-making practices (Adelson, 2005; Richmond & Ross, 2009). The picture of health conditions that emerges indicates that Indigenous peoples are increasingly living with chronic conditions as a result of inequalities in the SDOH, requiring access not only to primary but also to secondary and tertiary prevention interventions (Lavoie, O'Neil, Reading, & Allard, 2008).

Access to healthcare is an important determinant of Indigenous health, however, disparities in access that are experienced by Indigenous people are in stark contrast to Canada's portrayal of its health care system as one of the best in the world. Often the services that are provisioned to Indigenous communities, as well as those mainstream services found off-reserve, do not offer traditional or culturally safe care and fail to address the health inequalities specific to the Indigenous population (Adelson, 2005). Further, Indigenous clients continue to have negative experiences within the health care system, such as discrimination and stigmatisation, marking the persistence of colonial attitudes and beliefs within this institution (Allan & Smylie, 2015; Hole et al., 2015). These disparities are also due in part to the way in which healthcare services are funded and provisioned to Indigenous people by various levels of government.

¹ We prefer to replace the use of the word "Aboriginal" with the more uniting and less colonising term "Indigenous" to refer to First Nations, Inuit and Métis peoples of Canada.

The relationship between the government of Canada and Indigenous peoples is unique in that it is characterised by a complicated legislative and constitutional regime. This regime has resulted in an unequal and fractured manner of delivering services and the outcome has been that of jurisdictional confusion and policy vacuums regarding many aspects of Indigenous people's lives (MacIntosh, 2006). In Canada, primary health care services for on-reserve First Nations are under federal jurisdiction while primary health care for other Canadians and all other Indigenous peoples are under provincial jurisdiction. This current national health care system is a publicly-financed, publicly-delivered system, managed by the provinces under the umbrella of the *1984 Canada Health Act*. On-reserve services for First Nations in the form of health centers now complement this system, but they remain separately funded by the federal government. Physicians who are paid by the provinces visit the health centers, however, Indigenous patients who are in need of secondary or tertiary care in between health center visits are transported to the nearest provincial referral center. This moves Indigenous patients out of their communities, often at great financial and emotional cost, and disrupts their continuum of care. Indigenous people living on-reserve may also choose to seek health care through the provincial system because access to services may be quicker and because of confidentiality concerns with on-reserve services. Despite improved services in many cases, Indigenous patients seeking care outside of their community may experience culturally unsafe care, racism, discrimination and stereotyping from service providers, reinforcing historical colonial relationships (Jacklin et al., 2017).

In many cases where the question of jurisdiction arises, both federal and provincial levels of government attempt to avoid responsibility for the health and wellbeing of Indigenous peoples in Canada (MacIntosh, 2006). The concept of Jordan's Principle, which calls for the needs of the child to be put first in treatment decisions affected by jurisdictional disputes over responsibility for status Indian or Inuit children, arose as a result of the failings of federal and provincial governments to resolve fiduciary responsibility for a First Nations child from a

reserve community in northern Manitoba (Lavallee, 2005). As a result of this dispute, Jordan was never given the chance to experience home and community, succumbing to his illness in hospital while the federal and provincial governments argued over who would pay for his foster home care (Lavallee, 2005). It is not surprising to see that most provinces view First Nations health as an *Indian* issue and as such within federal jurisdiction and an issue to be addressed through federal funding and programming (MacIntosh, 2006). The participation of all three levels of government creates a highly complicated and uncoordinated system (Lavoie et al., 2005) characterised by gaps in service and overlapping coverage. It also results in program duplication and inconsistencies (Minore & Katt 2007).

For decades, Indigenous peoples in Canada have sought greater self-determination, for example; control over local health services (Belanger & Newhouse, 2008). Three notable changes have occurred in the landscape of Indigenous health policy and politics in Canada in the last forty years, increasing Indigenous control over community health services. These shifts hold more promise for Indigenous communities seeking self-determination, as they move away from top-down approaches to policy that perpetuate colonial control. The federal Health Transfer Policy (HTP), the Aboriginal Healing and Wellness Strategy (AHWS) in Ontario and the Tripartite Partnership Agreement (TPA) in British Columbia all provide Indigenous peoples with some degree of control over the health service delivery and decision-making processes in their communities. These policies and partnerships illustrate that self-determination is not simply either present or absent in Indigenous health policy, but rather, self-determination develops along a continuum. Understanding the development of self-determination in Indigenous health policy as a continuum can help shape the discussion about what Indigenous self-determination means for Indigenous people and how it can or should be enacted through health policy. This research suggests that Indigenous health policies are far more likely to yield substantive health improvements if they are developed as part of a continuing and genuine partnership between Indigenous communities

and government with the understanding that Indigenous people and communities design and implement their community health programs and policies as they see fit.

Indigenous Health Policy in Canada

The first development of the Indigenous community-controlled health sector occurred in 1988, with the establishment of the HTP, a policy that offers an opportunity to First Nations on-reserve south of the 60th parallel to take on the administration of a range of community-based and regional programs through multi-year agreements with the federal government (Wigmore & Conn, 2003). The process includes the transfer of knowledge, capacity and funds so that communities can manage and administer their health resources based on their community needs and priorities (Health Canada, 2003). The HTP envisioned the transfer of existing community-based and regional services to a single community or a group mandated by communities. This process allows for communities to gain ground with some of the jurisdictional hurdles, which are so often obstacles to success.

The second development occurred in the 1990s with the bureaucratisation of Indigenous health and the establishment of mechanisms and processes for the Indigenous community-controlled sector to collaborate with government policymakers in health, education and other sectors. Partnerships became the framework for relationships between different levels of government and Indigenous peoples. As a result, the first provincial Indigenous health policy emerged. Ontario's AHWS was formally launched in 1994 in response to high levels of family violence and low health status among the Indigenous population (Ministry of Community and Social Services, 2012). It created a formal partnership between 14 Indigenous Provincial/Territorial Organisations (PTOs), independent First Nations, and provincial ministries where Indigenous communities and government partners had shared responsibilities for overseeing health program delivery.

The third and most recent development occurred with the signing of the British Columbia TPA on First Nation Health Governance in 2011. The TPA transfers control of funding, managing,

designing and delivering Indigenous health services from the federal government directly to First Nations organisations through the newly established First Nations Health Authority (FHNA), which incorporates cultural knowledge, beliefs, values and models of healing into the design and delivery of health programs, while opening pathways to integrate mainstream services (Kelly, 2011; Lavoie et al., 2015).

Several scholars have explored whether the development of these three policies have positively affected health outcomes or administrative processes at the community level (Dwyer, Boulton, Lavoie, Tenbensen & Cumming, 2013; Dwyer, Lavoie, O'Donnell, Marlina, & Sullivan, 2011; Lavoie, Boulton & Dwyer, 2010; Lavoie, Forget, Dahl, Prakash, Martens, & O'Neil, 2010; Lavoie, Gervais, Toner, Bergeron & Thomas, 2011; Lavoie et al., 2005; Warry, 1998). Many of these studies have found that while these policy changes may improve access to health services and community empowerment, they come with bureaucratic and administrative challenges operating at the community level. For example, a major setback of the HTP has been that the federal government has not been able to effectively consult with Indigenous peoples or adequately address the heterogeneity of interests and experiences in Indigenous populations. However, Jacklin and Warry (2004) note, "In light of the rhetoric of self-determination that was part of the development and marketing of the Health Transfer, it can be argued that the policy has enhanced local capacity in health governance and administration and has assisted in the initial steps toward self-determination in health care" (p. 219). Other benefits of the HTP include improved health awareness, culturally sensitive care, and empowerment (Dwyer et al., 2011; Lavoie et al., 2005, 2010). Similarly, although the AHWS represents a clear effort to include the voices of First Nations, Inuit and Métis peoples, the policy addresses Indigenous peoples as a homogeneous group, requiring Indigenous groups and organisations to reach consensus rather than address their individual values and interests. While the AHWS is able to engage a broader range of Indigenous groups, the British Columbia TPA presents a more comprehensive governance strategy than HTP or AHWS in

terms of the degree of control that Indigenous communities and organisations have in determining resource allocation, program design and delivery strategies for health services. However, scholars reveal the weakness of the TPA in limiting the space for other Indigenous groups such as Métis, Inuit and urban Indigenous peoples, to undertake political capacity (Lavoie et al., 2015). Still, it could be argued that this model resembles more closely what Indigenous peoples consider *self-determination* and/or *empowerment*.

Despite the range of research on the outcomes of these policies, few scholars have delved deeper into how colonial processes and institutional structures have shaped relationships between the Indigenous health policy sector and the Canadian state. Little has been written about the relationships between the Indigenous health policy sector and local, provincial/territorial and federal levels of government. More attention needs to be given to the impact of colonial structures and power relations that continue to contribute to the poor health and social inequalities in Canadian society. Thus, the underlying research questions guiding this study ask: How do Indigenous communities understand and experience self-determination and community-controlled health care? In what ways do Indigenous communities perceive collaborative arrangements and partnerships between communities, organisations and various levels of government in the health policy process? We explore how Indigenous people and community stakeholders in Canada understand terms such as *self-determination* and *health* and draw conclusions about collaborative efforts between the government and Indigenous communities to support community-controlled health care. To this end, this paper aims to inform broader discussions about Indigenous self-determination, community health and wellbeing while contributing to a larger process of decolonisation and reconciliation.

Methodology

The McMaster Research Ethics Review Board (MREB) approved our research. In addition to MREB approval, we also obtained ethics review and approval from the local Indigenous Research Review Committee, and by local leaders and

health administrators in each community that we worked with. Our project employed a community-based participatory research (CBPR) paradigm that utilised interviews, and the gathering of stories through discussion circles as the primary research methods. These qualitative, Indigenous research methods were chosen for their potential to produce rich data and their ability to add to understandings about what community members understood by such terms as *self-determination* and *health* (Lavallée, 2009). As a result of these discussions, we were able to draw conclusions about respective health policies that were helpful to these communities as they continue to participate in broader discussions about self-determination, health and wellbeing. In adopting this methodology, we constructed the presentation of the discourses and analyses of policy strengths and weaknesses gained through narratives from community members themselves.

Community-Based Participatory Research

This research is grounded in principles of community-based involvement, control, and ownership of research (National Aboriginal Health Organization [NAHO], 2004; Schnarch, 2004). This is a key consideration in the research approach we adopted with community partners, and also in the application of health care as a means to support self-determination. CBPR projects share underlying goals of influencing social change, and equitably involving community partners in the research process (Minkler & Wallerstein, 2003). This approach involves community stakeholders at all levels of the research process from inception through knowledge mobilisation. A CBPR approach was appropriate for this research given the need to learn from Indigenous peoples, how they experience health care at different levels, and to listen to their articulation of the challenges they face. Indigenous peoples are often excluded and disengaged from the research process (Castellano & Reading 2010; Jackson 1993; Mitchell & Baker 2005; Porsanger 2004) CBPR addresses this by creating bridges between researchers and communities, through the use of shared knowledge and experiences. Over the course of a two year period, the research team travelled to

five Northern Ontario Indigenous communities and spoke with key Indigenous and non-Indigenous stakeholders involved in Indigenous health policy and opened up a dialogue within the respective policy communities about Indigenous health care policies in Canada. The four principles of OCAP, namely: First Nations ownership, control, access and possession were adapted to fit the context of the study. With respect to ownership and control, our approach emphasised consensus in all aspects of the research process rather than a power relationship between community and university stakeholder. For example, community members worked with the research team to shape the research questions which moved beyond exploring quantitative indicators of health outcomes and sought more detailed information about the relationship between Indigenous people and the state in the development, implementation and evaluation of health policy. Access to research results was created in the form of research progress reports and community and staff presentations. Raw interview and discussion circle data were held in the possession of the university researcher and with each community's health centre director. A research agreement was put in place with the community partner incorporating these four principles.

Recruitment, Sample and Data Collection

The research team was asked to facilitate and write each of the community's five year health plans, a process required under the Health Transfer Policy process. Part of this position involved working with other community consultants interviewing stakeholders about their perception of how things have changed in the health policy arena. As we worked with each community, we conducted a separate set of interviews and discussion circles with Indigenous and non-Indigenous stakeholders so we could delve deeper into an analysis of the relationships between Indigenous communities and government in the health policy process.

Methodologically and analytically, we followed knowledge pathways articulated and experienced by community members through discussion circles. This qualitative approach was chosen to

generate discussion by community members, health professionals and administrators and government officials around community-controlled health care. The goal was to begin to unravel the health policy process by mapping some of the key political stakeholders in Indigenous health and to reflect upon the processes and institutional structures that shape relations between the Indigenous community-controlled health sector and government. Discussion circles in particular were felt to be the best way to explore Indigenous health policy as they enabled discussion by permitting respondents to raise both concurring and dissenting opinions. The research team conducted interviews and discussion circles with 108 participants (see Table 1) between November of 2009 and December of 2011. We used a snowball selection process: colleagues suggested initial contacts and then, during consultations, participants suggested other important stakeholders to contact.

Analysis

The Indigenous paradigm utilised in this research was one that moved beyond more traditional analytical lenses and approaches. The narratives embedded throughout the research are part of this process of giving voice and authenticity to community members and of permitting them to construct their own analyses of health, wellbeing, and self-determination as they live their daily lives and frame their hopes for policy change. We spoke with community members, leaders, health care providers, administrators, government and non-government stakeholders and discussed their priorities, goals and challenges in the health policy process.

The interviews and discussion circles were audio recorded with participant permission, and field notes were maintained. The recording was transcribed verbatim and analysed by the research team for themes emerging from the text. At the end of each day, a formal debrief was conducted with our community partners to discuss data collection and any concerns regarding the content. The field notes were compared with the transcription to clarify and ensure completeness. An open analytic approach was used to explore the content of the text and themes were drawn

from the text. The research team reviewed the transcripts independently. Then, the primary researcher identified key passages for consideration and compared the findings and came up with larger conceptual categories that seemed to emerge from the text. The larger categories were then used as a basis for coding the text. The research team actively reviewed and revised the categories using an inductive and iterative process and sought out passages that contradicted the themes.

By conducting in depth, on the ground analysis, the strengths and weaknesses of these policies are unearthed in ways that expose the localised *messiness* of self-determination that otherwise would not have been as visible. This methodology does not begin with externally defined hypotheses but builds a capacity for scholars to *live along* with members of the community and permit them to frame the problems that they face and to reflect upon the processes and institutional structures that shape relations between the Indigenous community-controlled health sector and government.

Results

Four main cohorts emerged in this study.

- i. Indigenous and non-Indigenous health service providers including health workers, registered nurses, physicians, program coordinators, managers and health directors;
- ii. Community members both on and off reserve, including Chief and Council and community elders ;
- iii. Indigenous and non-Indigenous government bureaucrats at the community, provincial and federal levels involved in Indigenous health policy and Indigenous affairs;
- iv. Indigenous organisations involved in the health policy process.

Table 1: Description of the interviews and discussion circles by category, number and date.

Interview Group	# of Interviews Conducted	Interview Dates
Federal Bureaucrats	15	November 2009 - January 2010
Provincial Bureaucrats	18	January 2010 - December 2010
Chief and Council	7	N/A
Elders	4	N/A
Health Service Providers	25	April 2011 - December 2011
Health Administrators	22	April 2011 - December 2011
Indigenous Organisations (National, Provincial and PTOs)	8	N/A
Others: Community Members, Consultants, etc.	9	N/A

Five major interrelated categories emerged from our analysis: 1) tension with government stakeholders, 2) colonisation and assimilation, 3) coordination of health service development and delivery, 4) community partnerships and empowerment, and 5) perceptions of community-controlled health care. These themes are reported on and discussed below.

Tension with Government Stakeholders

From the perspective of critical Indigenous health policy, the ways in which community

control and community-government collaboration are defined by Indigenous and government bureaucrats is captivating. The dynamics between these concepts becomes highly complex, particularly in Ontario where the Indigenous population is so diverse. This diversity can create tensions related to contemporary Indigenous identity. This tension is partly due to the fact that the government comes to the table with its own interpretation of what community-control health care should mean. As a result, communities continue to have feelings of anger and mistrust towards government:

You look at the level of dependency...the government has created this dependency relationship for First Nations. And we can't do anything unless it's government funded.

Because the government gives us funding, we're expected to make a difference. And one of the things that I've noticed is that because we're committed and we have passion so we're trying to make a difference that we do more with less and we do it all the time. And so we've kind of set ourselves up that because we can do more with less that the expectation from government is that we'll continue to do that.

You really need to have a good grasp on things like proposals and you need to be on top of things and be aware when opportunities come up to get funding from the government for a particular project and to jump on it...but you need to ask, how do you create a health system based on projects anyway...That's always a challenge.

Even under Health Transfer some of the dollars are too small. They haven't grown with the times...Health Transfers have been there for sixteen years and how much have they grown, maybe ten percent. And the population has doubled. When you first set up Health Transfer you might have had eighty-seven people in one community and now there's a hundred and thirty.

Colonisation and Assimilation

Not only is there tension with government stakeholders, but this tension also reverberates at the community level amongst members. In our discussions, assimilation and colonisation were themes that were consistently brought up:

If you look at the policies of assimilation and all those things, it's based on what can

they do to get the land; we were the first people on this country and what did the people that came from Europe - what did they do to get that land and develop their policies and violence. And so it has perpetuated because we have been violated and what happens is we tend to become the violators as well, so lateral violence.

When you look at the issues in communities, it's about identity, who we are, when you get into the addictions, the alcohol, the drugs, issues around violence, not having self-worth about my job, housing issues - these are all deep rooted issues and to think that you're going to eradicate all of this just like that, that's crazy.

One of the consultants that we were working with described this process as one of internal colonialism. She identified the problem as one whereby government allocates a minimal amount of services, money and resources to Indigenous communities which pits people against one another in the search for funds. It also creates, she added, the perception that they cannot function without infighting amongst themselves. Taiaiake Alfred (2009) writes, "This harm has resulted in the erosion of trust and of the social bonds that are essential to a people's capacity to sustain themselves as individuals and as collectivities" (p. 52).

Coordination of Health Service Development and Delivery

The health managers that we spoke with discussed some of the challenges they experienced under the HTP process. They told us that while health programs are urgently needed within Indigenous communities, the rapid evolution of Indigenous health care among their communities has brought about changes that can get in the way of the development of integrated health services. Many of the managers spoke of funding challenges and the rigidity of reporting requirements or program goals that often vary tremendously between funding streams and provide challenges to the provision of integrated services. Although the way that Indigenous health policy is conceptualised has changed over the past many years, the model of how health policy is practiced on the ground continuously evolves. Others find that there are definite advantages and that the current integrated model is indeed effective. Health services have become increasingly holistic; services of traditional

healers, nurse practitioners and dieticians are often provided at the community level. These services present a contrast to most communities elsewhere in Canada without additional health services in place. It is possible for communities to reclaim power back from government. Change is unavoidable as each generation of Indigenous leadership will bring a different perspective to activism and advocacy.

Community Partnerships and Empowerment: Building Local Health Capacity

Whereas many barriers need to be overcome in the provision of integrated services in Indigenous health among the five communities, in our discussions and interviews, we found that there are positive processes occurring at the community level:

I think we're making progress and there is a method to the madness. We are starting to build capacity. We're focusing on infrastructure and addressing social problems and things like health. We're working on fixing housing and extending water lines to make sure that people live in a healthy environment. We're starting to pay more attention to keeping a healthy environment in the homes, in the offices. Even the land, we have clean ups. We're starting to focus more on economic development, creating business opportunities and now we're focusing on our cultural, social and spiritual development and strengthening the governance component and we're having a lot of success. You can network and build best practices and find out who's doing things that are great. You need to be able to open up your eyes and see that there's a better world out there.

Marian Maar (2004) suggests that partnerships between the primary health care organisations and the local federally-funded health authorities are contributing to local health empowerment in many ways. An empowered Indigenous model is driving these communities to a more cooperative and integrated system. This is allowing each First Nation to develop their own creation for learning, to rethink the dimensions of their health care work. It is allowing each community to look at their own work and needs through a different lens that is consistent with the Indigenous traditional ways in partnership with western health models so that their citizens have clear

choices and options. The communities and leadership have witnessed the value of partnership:

So they're good, bureaucrats are good even provincially here in the system for these communities. It's different dollars not what they need or what they want sometimes, but it does work. You've got to reconcile, people are people, we're all in this together and you've got to make their job easier or give them some knowledge that might help them in their day to day work, in their briefing.

This community's relationship with government could be viewed as a different type of activism. This type involves a model of power that takes into account the broader social context within which power relationships are established and maintained. This approach is in contrast to earlier activism in the 1960s with the creation of the National Indian Brotherhood (NIB) for example, now the Assembly of First Nations (AFN), needed by Indigenous people for sustained mobilisation. The NIB established a base for the dissemination of information, large-scale structural support for strategic organisation of activities and a degree of unity to the efforts and perspectives of Indigenous people across Canada (Fenwick, 2003). Indigenous communities and their organisations are now using their leaders, organisations and their champions to exercise political agency through relationships with other wielders of power. MacIntosh (2008) suggests that "many community final reports/self evaluations of transfer indicate that community health improvements were in part the result of partnering or otherwise forming new relationships with provincial agencies" (p. 99). Although power imbalances will continue to exist, there are many sites of power in that no single structure or institution is considered politically supreme.

Perceptions of Community-Controlled Health Care

Much of the literature on health transfer speaks to the positive nature of transferring varying aspects of governance responsibilities from federal hands to Indigenous ones. When asked about community control over healthcare and whether health transfer has had positive impacts on the health of the community, we received the following responses:

I have a great deal of faith and I think that our community is strong and everybody's moving at a different pace and growing and developing. Some communities are very clear about where they want to go and others are moving in that direction.

I think our community is highly resourceful and we don't want the status quo, we want to have good health and access to services just like any other Canadian. That's all we want. Getting there has been a long road for us, it can be troubling and not clear because there are just so many other things going on.

Others are not as optimistic about the health transfer process and believe that the health transfer process perpetuates a system of state run operations. Under health transfer, the government also sees the Indigenous health programs and operations as its own:

We have to always remember that FNIHB [the government] is the banker, that's where we get our money from and until that changes, they are going to continue to influence our future.

The narrative described above offers a new set of tools for analysing the dynamics and tensions of joint policy development. With this analytical capability, we were able to show the deeper structure of the process which produced these dynamics. These narratives are integral to the telling itself of the story and provide insights about how particular policies work in the given communities. Herbert (2003) argues that the analysis, interpretations and reporting of Indigenous stories within the context of research is not about the generalisations of experiences but about the experiences themselves, based on personal and social stories that give meaning to the phenomenon.

Conclusion

In 1990, Sally Weaver predicted that a paradigm shift in policy-making was *inevitable* because old paradigm *solutions* would become less tenable. New paradigms would emerge from forging relationships with Indigenous communities that gave them the lead voice for analysing their own situations. New paradigms would emerge that reveal the "outmoded analysis of the state's obligation to Aboriginal peoples" (p. 8). Weaver identified joint policy-making forums and joint

management systems as part of that new thinking (Weaver, 1990). Integrative health models call our attention to the importance of policy development, to epistemological issues in relation to that development, and to the dynamics of social processes in policy-making that can facilitate social change. These services in turn complement what the federal government offers through transfer and other contribution agreements. These strategies include the blending of mainstream, rural and urban health services with Indigenous based health services; integration at the First Nations level including community health services and community sectors such as education and housing; as well as continuation of the partnership between non-Indigenous community health services and traditional healing strategies. The flexibility to work with organisations and the communities in the surrounding area have empowered Indigenous peoples when there are a plethora of factors working against them.

Most recently in 2011, British Columbia entered into a Tripartite Framework Agreement with First Nations that has enlisted a more comprehensive health care system in British Columbia by creating partnerships between the federal government, the provincial government and First Nations. However, as Lavoie and her colleagues (2015) point out, "it also highlights a policy weakness in the conceptualization of self-government which limits the political space some First Nations, Métis, and Inuit have in the BC and the Canadian political landscapes" (p. 12). The British Columbia Tripartite Framework Agreement could set a very important precedent in Canada whereby Indigenous peoples will not only have some decision making authority in health policy, but have complete control in the planning, implementation and management of their health care.

To date, Indigenous health policies in Canada have existed on a continuum consisting of government controlled health policy and the need to include diverse Indigenous groups, with the need for comprehensive control from program funding and design to implementation. For example, the AHWS attempts to involve a range of diverse Indigenous groups, but has several limitations in the extent to which these groups have control over design and

implementation processes. Relatively speaking, the TPA provides a greater degree of control over design and implementation processes, but is arguably less sensitive to the unique priorities of First Nations, Inuit and Métis communities. Despite the progress that Indigenous health policies have made, there remains a need to transcend the limitations of current policy models by adequately addressing issues related to both sensitivity to the diverse Indigenous groups as well as the degree of control over health service funding, development, and community delivery and implementation. Moving forward, Indigenous health policies should feature a comprehensive design that attempts to maximise the benefits of both ends of the current health policy continuum. That is, they should aim to provide a high degree of control while creating mechanisms to ensure that individual communities are able to guide the development and implementation of health programs and services that are relevant to their specific health care needs.

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