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# Achieving Primary Health Care equity with Indigenous Peoples:

## A policy for an Alberta Indigenous Primary Health Care Board

Varying degrees of Primary Health Care (PHC) service exists within First Nations, Métis and urban contexts, illustrating a service environment that is fragmented, under-resourced and disconnected from each other, as well as from mainstream PHC services. For Indigenous communities, federal PHC policy translates into a limited model of PHC with significant deficiencies of professional and system resources. Moreover, structural barriers and inconsistent political will to enable cross-sector collaboration impedes progress towards sustainable solutions for Indigenous PHC. Most critically, fragmented PHC drives inequities in access and outcomes. Populations and individuals who lack economic resources and who have poor social support networks are among those least likely to have comprehensive PHC delivery and experience its benefits.



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## Description of the policy issue

In Canada and other nations, primary healthcare (PHC) transformation continues to be identified as a key pathway to achieve health equity for Indigenous peoples. However, varying degrees of PHC service exists within First Nations, Métis and urban contexts, illustrating a service that is fragmented, under-resourced and disconnected from each other, as well as from mainstream PHC services. For First Nations communities, federal PHC policy translates into a limited model of PHC with significant deficiencies of professional and system resources. Federal policy makers argue PHC is a shared responsibility with the province, as demonstrated by a funding transfer to the provincial health insurance program for core elements of PHC service. In defining their focus on First Nations communities, and a limited scope of PHC services, federal policy makers have delineated a jurisdictional boundary that is distinct from provincial responsibilities.

Moreover, structural barriers and inconsistent political will to enable cross-sector collaboration impedes progress towards sustainable solutions for Indigenous PHC. Complex or absent funding processes and mechanisms, and disconnected processes in federal, provincial, and community-level health system structures, complicate basic health service delivery for Indigenous peoples, whereas this type of care is readily available to non-Indigenous populations. This description is not unlike that which exists when considering PHC delivery to Indigenous constituents in the province of Alberta. Historical inequities, shaped by jurisdictional uncertainties and disputes, have created a situation where each Indigenous group protects their resources, with separations maintained as each advocate for the right to self-determination, development and administration of health programs, and access to mainstream social and health services without discrimination (1).

## Background

PHC, as outlined by the 1978 Declaration of Alma Ata, is inclusive of promoting health, preventing disease and managing the poor health of local populations by maximizing the use of local resources (2). International evidence suggests that PHC can produce a range of economic and patient benefits through its potential to improve health outcomes (e.g., increased life expectancy), health system efficiency (e.g., reduced total hospitalizations and avoidable admissions) and health equity (e.g., improved equitable access to healthcare and equitable health outcomes) while supporting wellness and health (3-5).

In Canada, the structure of the current state of PHC creates barriers among Indigenous peoples attempting to access PHC services. Meanwhile, fragmentation of PHC is viewed as the root cause of unsustainable and low-quality health systems (6). Current PHC delivery is characterized by prioritized narrow investments, and disconnected systems, services, and providers. Efficiency discourses have shaped the language used by healthcare providers and placed emphasis on time pressures, care processes, and organizational tensions which comprise care and best practice (7). There is little impetus to be harmonized with other system components, or only superficial attempts at building relationships between the components that could

offer the opportunity for whole-person care with improved satisfaction. Most critically, fragmented PHC drives inequities in access and outcomes. Populations and individuals who are lacking economic resources and who have poor social support networks are among those least likely to have comprehensive PHC delivery and experience its benefits.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) provides direction towards equitable PHC for Indigenous Peoples in Alberta, based on the right of Indigenous Peoples to the highest attainable standard of physical and mental health, and right to access, without discrimination, to all social and health services. Furthermore, the Truth and Reconciliation Commission of Canada's (1, 8) health legacy **calls to action** set a framework for grounding PHC policy action within the following principle truths:

1. Health inequities experienced by Indigenous people are rooted in determinants specific to their social, cultural, and political contexts. Colonization is a prime driver of ongoing social and health inequities.
2. Healing involves addressing impacts from multi-generational adverse life experiences, rectifying ongoing social resource inequities, and reconnecting with Indigenous culture and healing practices.
3. Complicity with ongoing colonization manifests as a healthcare system that is too often **under-resourced** and **ill-equipped** to address the health disparities specific to Indigenous populations.

## Mobilizing towards primary health care equity with Indigenous populations

A widening health gap between Indigenous and non-Indigenous people in Alberta warrants critical health policy action. Achieving PHC equity with Indigenous populations speaks to the need for systemic transformation framed within the decolonization of health care by embracing reconciliation, cultural safety and structural competency. The extent to which the mainstream system can truly transform to be inclusive, competent and safe for Indigenous patients will take ongoing and concerted effort. For this to happen, appropriate financial resources and Indigenous health systems, and policy directions, are essential. The following descriptions highlight the contexts and policy opportunities for reform, and needed transformation of PHC for Indigenous populations within Alberta.

### Indigenous governance for advancing PHC

In Alberta, there has been a preference to maintain a mainstream health structure, with intermittent formation of under-resourced Indigenous health committees or programs with low penetrance and impact. Mainstream PHC services mandated by provincial policy makers exclude the needs of Indigenous populations and argue that jurisdictional responsibilities limit their scope to off-reserve contexts, often refusing to allow mainstream resources to cross First Nations reserve boundaries. It is apparent that in

## PRIMARY HEALTH CARE EQUITY WITH INDIGENOUS PEOPLES

Alberta, the jurisdictional divide also disconnects federal and provincial PHC policy makers who appear to be working towards similar goals, but do so without meaningful collaboration.

Of note, the Alberta provincial ministry of health has no strategic directions, policy statement or Office with regards to Indigenous Peoples health. In the 2020-2021 health ministry annual report, Indigenous PHC is not mentioned as a strategic direction. Instead, the report notes rather nominal investments including the Indigenous Virtual Care Clinic and the Indigenous ARP (9). Alberta Health Services (AHS) facilitates broad Indigenous health direction through the Indigenous Wellness Core, guided by a commitment statement entitled ‘Roadmap to Wellness’. This roadmap describes intention to advance system wide policy innovations for transforming health services and systems in which PHC is identified as a priority direction (10). However, neither the Indigenous Wellness Core nor its Primary Health Care working group have overarching governance authority for setting PHC direction or binding the province in the resourcing needed to advance PHC for Indigenous populations. Furthering the jurisdictional divide, the federal government restricts its responsibility for health care provision to “on-reserve” service, leaving the provincial governments to cover healthcare for Métis, as well as for First Nations and Inuit peoples living off-reserve (11). Nonetheless, Indigenous Services Canada defines itself as a PHC Authority that funds specific programs, services and strategies to improve the health of Indigenous Peoples as part of a shared responsibility between federal, provincial, territorial and Indigenous partners (12). The Health Co-Management Committee is a unique structure in Alberta, where First Nations and the federal government jointly oversees Alberta-directed federal health funding (13). While focused on federally mandated First Nations on-reserve health program funding decisions, the committee does not have a specific PHC system mandate.

In British Columbia (B.C.), the First Nations Health Authority (FNHA) is an example of a governance-based approach to address healthcare fragmentation. The Health Authority was born from the ‘Tripartite First Nations Health Plan’ (14) developed between the First Nations Leadership Council, the Government of Canada and the Government of British Columbia. A self-governing approach to health care for First Nations populations in B.C., the FNHA has assumed administrative responsibilities previously held by Health Canada but with a comprehensive governance structure guided by the First Nations community. Taking lessons from B.C.’s FNHA’s model, a governance-based approach for Indigenous PHC in Alberta offers a potential policy opportunity for improving the health and wellbeing of Indigenous communities.

### Equitable access to high-quality and safe PHC

The reality is that Indigenous people continue to experience access barriers to care within a PHC system staffed by mostly non-Indigenous providers, framed for non-Indigenous patient populations, organized by non-Indigenous PHC system leaders, and delivered within non-Indigenous contexts. Within mainstream PHC, Indigenous patients’ needs remain a small aspect and are often neglected. Systemic violence arising from racism, the underlying cause of access barriers also adversely influences quality and safety of PHC for Indigenous patients. Achieving equity of access, quality and safety within mainstream PHC systems requires transformation and intentional policy shifts within PHC organizational entities, such as Primary

Care Networks (PCNs), the AHS Primary Health Care Integration Network and the Primary Care Alliance – all of which have varying minimal initiatives for Indigenous PHC. Indigenous health is not a core mandate of these entities, as seen by the absence of organizational actions, structure and governance for addressing inequity and lack of Indigenous inclusion.

As mentioned, federally funded health care resources are limited in scope and exclude Indigenous populations that are off-reserve, non-status and Métis. As for provincially funded PHC services specifically for Indigenous Peoples, limited clinical resources (i.e., the Elbow River Healing Lodge, The Indigenous Wellness Clinic, the Indigenous Virtual Care Clinic and the Indigenous Alternative Relationship Plan) have emerged from local action, but do not reflect provincial strategic initiatives. In Ontario, 10 provincially funded Aboriginal Health Access Centres arose from its 1994 provincial Aboriginal Health Policy (15). These Indigenous community-led PHC organizations offer a wide basket of resources and play a strong role in improving the health and wellbeing of Indigenous communities throughout Ontario. To fully address the truth that PHC for Indigenous populations in Alberta is *under-resourced and under-funded*, Alberta requires provincial commitment to build Indigenous PHC infrastructure that is inclusive of all Indigenous Peoples.

### A robust PHC workforce for Indigenous populations

For most providers, Indigenous health will continue to be a small part of their knowledge and work reality. At the moment, all PHC providers are not mandated to access Indigenous health professional educational resources nor are they accountable to Indigenous health competency standards. To facilitate the inclusion of professional standards of Indigenous care quality, amendment to the Alberta Health Professions Act, along with policy shifts within health professional regulatory bodies and related professional associations, are required. Indigenous and non-Indigenous service providers who have intention to provide focused-care to Indigenous populations are a critical resource. For Indigenous trainees, structural barriers to educational institutions, compounded by toxic institutional racism, determine the numbers of graduates. Institutional educational barriers exist for both Indigenous and non-Indigenous trainees who may want to eventually focus practice within Indigenous communities. Clinical training within the current mainstream healthcare system perpetuates racism against Indigenous Peoples, undermining competency and safety. There are very few Indigenous-focused clinical training opportunities, and those that exist have limited capacity due to service provider and infrastructure gaps. Recently graduated PHC providers come face to face with a sparse Indigenous PHC system infrastructure and are thus recruited into mainstream clinical contexts, providing care to non-Indigenous populations. A reality of ‘more’ Indigenous-focused PHC providers hinges on PHC infrastructure.

### Advocacy for strengthening Indigenous PHC

In Ontario, the Indigenous Primary Health Care Council is a partnership among numerous provincially funded PHC services with a mandate to support the evolution of Indigenous PHC services provision and

planning. Inclusive of provincial, federal, First Nations and other Indigenous PHC entities, they provide ‘status neutral’ support to all Indigenous Peoples in Ontario. Governed as a collective of numerous Indigenous PHC organizations, they have become a central PHC entity that engages with provincial and federal policy makers and funders for the innovation of Indigenous PHC. While an intriguing direction for Alberta, our provincial ministry has not legislated investment into Indigenous PHC as Ontario has. Alberta’s three previously described Indigenous PHC entities do not achieve the critical organizational mass required to be an effective lobbying force.

An Indigenous PCN would help to build and connect Indigenous PHC infrastructure, as well as build its potential for advocacy. Each existing mainstream PCN receives per-capita funding for all individuals within their catchment areas, including those who are Indigenous. Reorganizing these funds to a provincial Indigenous PCN specific to the comprehensive care needs of Indigenous populations could support building critical infrastructure but requires political will, approvals and an oversight structure to facilitate.

### A key policy direction

Mobilizing towards Indigenous PHC equity demands policy actions within the previously described interdependent contexts. Each of these examples comes with their own strengths and limitations. Nonetheless, we identify a governance policy option that provides overarching reach for realizing an Indigenous-led and community-based PHC transformation that’s inclusive of all First Nations, non-Status Indigenous and Métis populations within Alberta. Improvement in Indigenous health outcomes in Alberta could be achieved through a combination of mutually supportive structural elements facilitated by having funding and policy responsibilities under a single accountability structure.

***A provincial public agency (a Board) on Indigenous PHC in Alberta offers a critical policy direction for improving the health and wellbeing of Indigenous communities, through an Indigenous-led and community-based PHC governance structure.***

Mandated through a multi-partite agreement, the Board will set ‘status-neutral’ PHC direction and policy for all Indigenous Peoples in Alberta, and address service gaps, reform delivery, foster collaboration and rectify jurisdictional ambiguity. The Board will hold governments and provincial PHC stakeholders accountable to attaining equitable PHC service infrastructure. It will also reinforce financial commitments and responsibilities, such as leveraging substantial commitment for Alberta Health funding of Indigenous PHC service. The Board will oversee emerging PHC infrastructure and work to address jurisdictional disputes, promote functional partnerships that unravel systemic barriers, and innovate collaborative cross-jurisdictional solutions, such as advocating for an Indigenous PCN.

By defining Indigenous PHC infrastructure as a critical element for effective training and partnering with educational institutions, the Board will work to coordinate training and learning opportunities in

Indigenous PHC sites, thereby fostering the development of a high-quality and safe PHC workforce for Indigenous populations. The Board will hold accountable, and interface with, other relevant professional associations, boards and committees in the province (e.g., Alberta Medical Association, College of Physicians & Surgeons of Alberta, Primary Health Care Integration Network) to strengthen an Indigenous PHC infrastructure.

## References

1. United Nations Declaration on the Rights of Indigenous Peoples (2008), p. 15 GA Res. 61/295 (Annex), UN GAOR, 61st Sess., Supp. No. 49, Vol. III, UN Doc. A/61/49
2. World Health Organization (1978). *Declaration of Alma-Ata*. World Health Organization. Geneva, retrieved from: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf).
3. World Health Organization (2008). Commission on Social Determinants of Health: Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization
4. World Health Organization. (2008). *The world health report 2008: primary health care now more than ever: Introduction and overview* (No. WHO/IER/WHR/08.1). World Health Organization.
5. Starfield, B. (2006). State of the art in research on equity in health. *Journal of Health Politics, Policy and Law*, 31(1), 11-32.
6. Stange, K.C. (2009). The problem of fragmentation and the need for integrative solutions. *The Annals of Family Medicine*, 7(2), 100-103.
7. Blanchet Garneau, A., Browne, A. J., & Varcoe, C. (2019). Understanding competing discourses as a basis for promoting equity in primary health care. *BMC Health Services Research*, 19(1), 1-11.
8. Davy, C., Harfield, S., McArthur, A., Munn, Z., & Brown, A. (2016). Access to primary health care services for Indigenous peoples: A framework synthesis. *International Journal for Equity in Health*, 15(1), 1-9.
9. Government of Alberta (2021). Annual Report Health 2020-2021. Edmonton: Government of Alberta.
10. Alberta Health Services (2018). Indigenous Health Transformational Roadmap 2018-2020.
11. Lavoie, J. (2018) Medicare and the care of First Nations, Métis and Inuit. *Health Economics, Policy and Law*.
12. Government of Canada (2020). Primary Health Care Authority. Ottawa: Government of Canada.
13. Alberta First Nations Health Co-Management. Retrieved from: <https://torch7.com/hcom/about-us/>
14. First Nations Health Authority Governance and Accountability. Retrieved from: <https://www.fnha.ca/about/governance-and-accountability>
15. Ontario Ministry of Health. Aboriginal Health Access Centres. Retrieved from: <https://www.ontario.ca/page/aboriginal-health-access-centres>

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