

## Self-Determination and Health Care

### Twenty Years of Canada's Indian Health Transfer Policy Revisited

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#### Abstract

*This essay studies the effects of decentralizing health care system governance on health outcomes in First Nations communities in Canada. This change in governance modes is epitomized by the federal government's 1988 Health Transfer Policy that allowed the responsibility for the delivery, management, and governance of health care to be transferred from the federal government to First Nations communities. This paper first reviews the theoretical framework for decentralization in which the policy is grounded, and then examines the policy's implementation over time. The author analyses the implications and outcomes of the policy and finishes by critically assessing the three main gaps in health care the policy fails to address.*

#### Introduction

The current health status among Aboriginal people in Canada is lower than the health status of Canadians generally, and has been for many decades. Much of this disparity may be attributed to differences in lifestyle, environment, social determinants and historical factors, but another factor at play may be differences in access to health care programs and services. The manners in which Aboriginals access health care resources, as well as the format of these resources, therefore influence their health status. In recent years, there has been a shift in beliefs about how health care ought to be delivered and managed in order to achieve the best possible health outcomes, which has in turn led to a shift in the governance of health care. This paper attempts to determine the effects of this shift in governance models on health outcomes in Aboriginal communities in Canada. One specific instance of this shift occurred when the Canadian federal government

introduced the Indian Health Transfer Policy in 1988, allowing the responsibility for the delivery, management, and governance of health care to be transferred from the federal government to First Nations communities. This paper will first review the theoretical framework for decentralization in which the policy is grounded, and then move to examine the policy's implementation over time. In the third section, the paper will analyze the implications and outcomes of the policy; the fourth section will finish by critically assessing the three main gaps in health care the policy fails to address. Though I make it clear in this article that the data necessary to specifically link governance models of health care to health status is lacking, my objective is to determine if the current transfer policy leads, as intended, to stronger health outcomes among Canada's First Nations population.

### **I. The Theoretical Framework for Decentralization**

The concept behind the Indian Health Transfer Policy, now commonly referred to the Health Transfer Policy (HTP), is that community-level management can better respond to local needs than can a centralized management model. This theory of decentralization is grounded in two observations. The first is that, in the case of First Nations communities where health concerns vary widely across different communities, community-level management can better assess the health needs and priorities within a specific community and thereby provide the most suitable services and programs. Centralized management, as embodied by Health Canada before the inception of the HTP, struggles to balance different needs, often provides only standardized programs and services, and thereby is unresponsive to local differences.

The second observation stems from the lack of improvement in Aboriginal health statuses after years of federal spending. It became clear that increasing spending was not a solution. Indeed, Waldram, Herring and Young (2006) emphasize the importance of local input: "a simple increase in health programs and services would not result in a substantial improvement in health status. What was required was increased input by Aboriginal peoples themselves" (ibid., 264-5). The HTP is therefore meant to enable First Nations to take control of the governance of the health care services they receive, thereby improving health outcomes in their communities.

Above and beyond the debate between localized versus centralized management is the question of if and how self-determination itself can act as a positive determinant on health outcomes. Indeed, Chandler and Lalonde's study (1998) on cultural continuity and adolescent suicide theorized that a person's identity is strongly linked to perception of

cultural continuity in time; they therefore hypothesized that in First Nations communities where there is a stronger sense of cultural continuity, the incidence of suicide among youth is lower. They applied this hypothesis to 196 First Nations bands in British Columbia and used six markers to establish the degree of cultural continuity present in a community, one of which was the control of health services by the individual band. They found that “the communities that have taken active steps to preserve and rehabilitate their own cultures are also those communities in which youth suicide rates are dramatically lower” (Chandler and Lalonde 1998, 215). The impact of the control of health services marker is also aligned to decreased rates of incidences of suicide (ibid., 211-2). Though Chandler and Lalonde’s study does not necessarily prove causation, it does positively correlate control over aspects of governance with better health outcomes, at least in terms of suicide and mental health. Therefore, beyond the benefits that local governance of health care can offer First Nations communities by ensuring local needs and priorities are met, local governance, or self-determination, is also positively related to health status with respect to mental health status in the British Columbia context.

## II. The HTP Over Time

The discourse around First Nations issues changed throughout the 1970s and 1980s, with increasing demands for self-determination on the part of First Nations. By the mid-1980s, the First Nations and Inuit Health Branch (FNIHB) of Health Canada, which has responsibility for Aboriginal health matters, was funding a series of “demonstration projects”: short-term experimental projects on community self-determination in the area of health care service delivery (Health Canada 2004, 2). In 1989, the Treasury Board of Canada approved the HTP, thereby putting in place a process to allow the transfer of control of health programs and services, as well as of funds, from FNIHB to First Nations communities. The policy applies to First Nations communities south of the 60<sup>th</sup> parallel only, and excludes Métis and Aboriginals living off a land base or reserve (Health Canada 2004, 1). The three original objectives of the HTP, centred on ensuring the efficient and effective transfer of governance to First Nations, were to:

enable Indian Bands to design health programs, establish services and allocate funds according to community health priorities; strengthen and enhance the accountability of Indian Bands to Band members; ensure public health and safety is maintained through adherence to mandatory programs (Health Canada 2005, 1).

These original objectives have not changed substantially in the latest reiteration of the HTP’s goals, however FNIHB has now placed increased emphasis on the importance of performance measurements. As a result, “the [newer objectives of FNIHB] highlight

service effectiveness and health improvements” (Health Canada 2005, 1). This move towards performance measurement is not unique to FNIHB as the entire federal government has been moving in this direction for a number of years, but this trend is at odds with the discourse of devolution in the federal-Aboriginal relationship: Waldram, Herring and Young (2006) rightly point out that the federal government’s role is now increasingly one of “funder” rather than of “provider” (232). I will return to the tension between performance measurement, as a precursor for standardization, and decentralization of direct responsibility in section III.

Uptake of the HTP was strong at the time of its creation: Eight transfer agreements had been signed and 67 First Nations were involved in pre-transfer planning by the fall of 1990 (Waldram, Herring and Young 2006, 270). By 2006, self-determination was in place for health care services in three quarter of the 599 eligible communities (Minore and Katt 2007, 5), though Health Canada acknowledges that not all communities were able to complete full transfers immediately and thus a number of communities found themselves at varying levels of self-determination (Health Canada 2004, 1).

From the outset though not all First Nations welcomed the HTP as a positive development, and critics point to two unintended or un-stated problems arising from the manner in which Health Canada implemented the HTP. The first problem arises from the funding formulas used to determine how many dollars a community will receive to provide health care services. First Nations organizations, including the Assembly of First Nations, and some researchers assert that the funding formulas transform this policy into a cost cutting measure for the government, or as Constance MacIntosh (2006) states, an “exercise in abandonment disguised as empowerment” (206). Two of the HTP’s long-standing academic critics, Jacklin and Warry (2004), explain that:

The final policy was not as comprehensive and flexible as suggested in the interim report. It did not include noninsured health benefits, dental, environmental health [clean water and sanitary living conditions], or training for Transfer, but did include a ‘no enrichment’ clause; that is, First Nation budgets were frozen at the time of transfer (219).

They argue that the federal government has tried for years to circumvent its responsibility to First Nations, especially on the question of health care. Though I am unqualified to provide a full legal analysis on this issue, it may be useful to unpack some arguments against the HTP through a legal lens.

The federal government claims it has no legal responsibility to provide health care to First Nations, and that it has only done so up until now on a humanitarian basis, or as a

“matter of policy” (Waldram, Herring and Young 2006, 181). It continues to argue that any reference to “medicine chests,” either in official treaties (it only appears in writing in Treaty 6) or in verbal negotiations, are not to be literally translated to mean that the government must provide a full range of health care services. Many First Nations, on the other hand, interpret oral agreements concerning medicine chests as meaning just that. Canadian courts have not provided any definite answer on the extent of the federal government’s responsibility in this area. Jacklin and Warry, however, in adopting the second interpretation, feel that the HTP goes against the federal government’s responsibility to provide health care to First Nations since it limits the amount of care First Nations receive due to constraints on funding. With regard to health care generally, a legal obligation may have ensured greater funding on the part of government since it would have wanted to avoid any lawsuits in relation to inadequacy of care, or even inadequacy of access to care. But the very fact that the federal government considers the provision of health care a policy matter rather than a legal one means that self-determination has a space in which to exist. If legally obliged to provide health care, the federal government may not have relinquished control of governance over health care, and communities may not have had the opportunity to slowly adopt self-determination, in the area of health care or in any other.

The second implementation problem with the HTP is the lack of control or flexibility towards issues that impact health but do not directly fall under the umbrella of health care, such as the environment, housing, infrastructure, unemployment or development. Without additional resource allocations to tackle these concurrent issues, there is little the decentralization of health care governance can do to ensure marked improvements in health status. First Nations themselves are quite aware of this divergence in expectations; Gregory, Russell, Hurd, Tyance and Sloan (1992) examined the pre-transfer process with the Gull Bay Band in Northern Ontario, and found that “virtually all the health care needs identified by the community leaders were beyond the scope of the health transfer policy. The divergence between desired changes in health care services and changes in programming possible under the transfer policy is pronounced” (216). Jacklin and Warry also underline the need for additional funding above and beyond a baseline funding for health care services. Communities that have poor health outcomes presumably need additional investments in areas other than health care since these communities are starting from a lower health outcome baseline than the mainstream, and we know that health care is not the sole determinant of an individual’s health.

The federal government conducted its own assessments of the HTP, the first one published by the Auditor General of Canada in 1997. The audit determined that the

framework established for the transfer of health programs to community control was sound and did allow First Nations to start managing their own health programs. However, the numerous reports Health Canada required from First Nations that signed transfer agreements did not actually provide performance information on health or measures of changes to health. Health Canada therefore had no way of properly determining if the HTP was having the desired effect of improving health outcomes and the process was contributing to the heavy reporting burden imposed on First Nations. In 2000, the Auditor General wrote a follow-up report and found that improvements still needed to be made because performance measurements of changes in health were still not being collected. In 2005, FNIHB-Health Canada conducted an evaluation of the HTP, though they contracted this evaluation to outside consultants from the Centre for Aboriginal Health Research. The evaluation was positive on the whole and indicated that the HTP goals were being met, though it also determined that the funding structure was problematic (as explained previously), that the accounting requirements for First Nations to Health Canada were a heavy load for managers to carry and that human resources and administrative staffing needs were often not prioritized, to the detriment of performance measurement. The evaluation also highlighted two trends in the relationship between FNIHB and First Nations. First, there is now uncertainty around FNIHB's role in providing health care as it is unclear if FNIHB is sharing power with communities, or if it is still meant to act as an overseeing institution. Secondly, there has been an increased push towards standardization, which I explore in the next section.

### **III. The Direct Consequences and Outcomes of the HTP**

The HTP was created with the unwritten assumption that the transfer of health care governance would necessarily lead to improvements in the health status of First Nations. But as mentioned previously, FNIHB did not adequately collect performance measurement information and therefore there is little quantitative data linking health care governance to health outcomes. The First Nations Regional Health Longitudinal Survey (RHS) conducted a pilot project in 2005 called the Community Ecological Survey which surveyed communities on questions of self-governance (First Nations RHS 2005, 14). Data was collected, but is still being analyzed and no report has been made public yet. The survey, now called the RHS Community Survey, is currently part of the phase two of data collection that the RHS is currently undertaking<sup>1</sup>. Once this collection phase is complete there will hopefully be data to quantifiably link governance models to health outcomes, perhaps in a similar way that Chandler and Lalonde demonstrated a link between cultural continuity and suicide rates.

<sup>1</sup> Leah Bartlett, RHS senior analyst, email correspondence with author, November 21-25, 2008.

We are thus currently left with qualitative case studies on which most academics have based their analyses of the HTP. These case studies offer critiques of the process of governance transfer, capacity and support issues surrounding health care provision and outcomes concerning First Nations' abilities to provide service, but they are mostly unable to identify whether or not these abilities lead to better health outcomes. I have, however, teased out four major trends among the outcomes of the HTP that seem to hold true across both positive and negative case studies.

#### *Increased Standardization*

Accountability has become a dominant issue in Canadian politics and policy-making, and the federal government must demonstrate that it is spending taxpayers' dollars in an efficient and effective manner. It therefore increases its demand for reporting and performance measurements even as it attempts to give up control of certain services and programs to First Nations. All this leads to an administrative maze that First Nations may find difficult to navigate, especially as they struggle to fund health care and properly resource their administrations. The Health Canada-FNIHB evaluation noted this may in turn lead to a feeling of disempowerment (Warry 1998) since managers within First Nations communities may feel that they are not veritably in control of their health care system, even though this same evaluation indicated little knowledge seems to be gained with standardization. Indeed, accountability requires some degree of standardization, both with respect to reporting and, to a degree, service delivery, yet this standardization is counter to the notion of self-determination at the local level since specific processes are imposed from the top-down on all communities in order to monitor and compare results. "It is paradoxical, but the success of Aboriginal self-determination can become its own limitation" (Minore and Katt 2007, 15). As self-determination gains momentum, the government feels the need to start bureaucratizing in order to measure impacts, all of which can lead to limitations, rules, and lack of flexibility when creating the unique services communities need and want.

#### *Little apparent health outcome improvements but increased capacity*

The health status of many First Nations communities is not good, especially in comparison to non-First Nations Canadians, and has not shown signs of improvements since the inception of the HTP; indeed some indicators, such as rates of diabetes, obesity and respiratory disease/lung problems even show sign of increasing (Jacklin and Warry 2004, 228). One mitigating factor may be that certain health indicators were never adequately measured to begin with; another is that an increase in health promotion activities such as screening may reveal the presence of diseases previously unknown to



the patient. Thus data from the past may not have been representative of the true health status of Aboriginals (Jacklin and Warry 2004, 228), but the fact remains the health statuses among Aboriginals are poor.

The case studies do however point to a positive trend in First Nations' increased capacity to accept governance in matters of health care, as well as in other areas. Warry (2007), despite deep criticisms of the HTP, concedes that "however flawed the Indian Health Transfer Policy is, it has resulted in slow improvement to health programs that are designed and delivered by Aboriginal people to meet the health needs found in First Nations" (160). Increased capacity in management can lead to self-governance agreements and additional positive outcomes, thus circling back to the positive link Chandler and Lalonde (1998) find between self-governance and health. Veenstra and Lomas (1999) second the importance of this link by demonstrating how social capital is not only good for individuals' health, but that governments can play a role in fostering social capital. The notion of self-government twinned with increased social capital may therefore have benefits on health status above and beyond improvement made by the local management of health care services.

#### *Funding rules have direct negative outcomes*

The funding rules in place between FNIHB and First Nations lack flexibility since not only are First Nations restricted in how the funds can be used, but the funds are also determined by inappropriate formulas that do not necessarily reflect the true number of users of the health care system. The formulas only consider those band members who actually live on reserves since the HTP only applies to care on reserves. The final number of dollars transferred may not properly consider who might use the health care system (for instance, someone who lives off the reserve, but still comes to the reserve to use programs and services). Furthermore, Lavoie (2004) rightly states that

Off-reserve services are also out of bounds. As nearly 40 per cent of the First Nation population actually lives in urban centres, the Canadian [Health Transfer] policy effectively limits the sphere over which First Nations can extend their influence and therefore their primary health care services (17).

The consequences of this under-funding means that already limited-resources must be stretched thin, since not only do First Nations health care systems work with patients who have lower than average health statuses, but they must also provide for people who were never counted in the funding formula to begin with. Such poor resources not only lead to direct negative impacts on the health care provided, but can also lead to the feeling that



paternalism is still at play. Jacklin and Warry (2004) point out that since transfer agreements have to be renewed every five years, with no guarantee that transfer contracts will in fact be renewed, communities must continually defend their choices (221), thereby counteracting the very intention of the HTP to put health care decisions in the hands of First Nations.

#### *Systems in continuous flux*

The final noticeable trend among the outcomes of the HTP is that the process of transfer is not immediate and does not follow the same patterns for all communities. Marion Maar (2004) argues that Aboriginal health care policies as a whole have been rapidly evolving over the past two decades, making it difficult for any one system to mature and for any evaluations to offer evidence linking governance models to health outcomes. In worst-case scenarios, the loss of a maturation phase might lead to a loss in the continuum of care, and patients may be directly negatively affected. Though less immediately worrisome, this continuous flux also leads to lack of valid and reliable health indicators since very few indicators are collected during periods of change, and no benchmarks can then be established. Finally, continuous change takes a toll on human resources, especially those involved in administration and management, as they continually contend with new rules, new negotiations, and new goals and expectations.

The Institute on Governance (1997), after examining the implications of the Royal Commission on Aboriginal Peoples on Canada's health care system, explains that time is necessary for Aboriginal self-governments to mature to the point of effectiveness, but in the meantime, the federal government can take short-term actions to support Aboriginal health care self-determination. They point to the provision of additional funding, a decrease in the reporting burden imposed by Health Canada and FNIHB on First Nations, as well as the provision of training to First Nations in order to allow them to better fulfill the administrative and accountability requirements laid out in transfer agreements.

#### **IV. Lacunae in the conception of the HTP**

The previous section of this paper reviewed the four major outcomes of the HTP, but in addition to these trends I believe there also exists three gaps in the very conception of the policy that will remain barriers to full and proper health care transfers and to improvements of health status among Aboriginals if they are not addressed. The first one reiterates the point made earlier about the policy's inability to address concurrent determinants of health alongside care services. The last two represent an analysis of the wider lacunae created by the HTP.

*Self-determination of health care is only one factor among a host of others*

The HTP only includes funds to cover the cost of primary care and does not account for additional spending a community might need to make in order to repair housing or infrastructures, to protect the physical environment or clean up contaminants on and around the reserve, invest in development, and reduce unemployment. All these factors contribute to poor health outcomes and if they are not addressed, there is very little hope of increasing First Nations' health statuses to match the statuses of the rest of Canadians. The HTP does not account for the presence of other government agencies such as Indian and Northern Affairs Canada (INAC), and without considering the manner in which these other agencies respond to self-determination in various areas, the policy cannot fully contribute to improving health outcomes.

Constance MacIntosh (2006) provides one concrete example of this reality from the Cree community of Pukatawagan in Manitoba where the presence of multiple agencies was problematic (206-7). In November 1993, a "boil water" order was issued. Both the provincial and federal governments abdicated responsibility for this problem and the federal government specified the community was responsible to solve the problem since it had taken over health care delivery under the HTP. The band argued that the federal government was responsible since it had built the faulty water and sanitation facility in the first place. Furthermore, the band explained that the HTP envelope had no dollars allocated to address this sort of issue, and so it would be forced to use money earmarked for primary health care to fix the water problem. After nine months, the federal government agreed to help move the discharge sewage pipe downstream to de-contaminate the reserve's drinking water supply, but the problem had to be addressed by INAC, rather than by Health Canada.

*The HTP does not solve jurisdictional grey areas*

The previous example not only depicts how the involvement of multiple agencies can complicate self-determination in a community and how problems beyond the scope of health care affect health, but also demonstrates that questions of jurisdiction are far from resolved. Lemchuck-Flavel and Jock (2004) argue that the grey area between provincial jurisdiction and federal policy can be enormous for First Nations (39). These grey areas become even more complicated as a third layer of delivery providers appears in the form of Aboriginal self-governments and administrations. The HTP does not illuminate these grey areas and provides no quick answer to the question of responsibility when

emergency situations such as in Pukatawagan surface. Unresolved questions on the issue of jurisdictional responsibility can only prove harmful to health outcomes.

*The HTP does not clarify accountability questions*

Despite the HTP's goal to "strengthen and enhance the accountability of Indian Bands to Band members" the question of accountability has not been clarified in the past two decades, and in fact may have only become more complicated as Health Canada, in an attempt to demonstrate performance measurement and comply with various Treasury Board rules, imposes increased reporting burdens on First Nations that do not lead to better accountability. As seen previously, standardization does not in fact correspond to better reporting or to better health outcomes. Who must account to whom for the spending of taxpayer dollars is further complicated by the attempts to strengthen accountability within First Nations themselves. Josée Lavoie (2004, *The Value and Challenges of Separate Services*) explains that

Chief and Council are elected by the whole membership [including those living off-reserve], but can only offer services to the on-reserve population [...] First Nations now find themselves culturally, politically and legally obligated to First Nation members living off-reserve, while at the same time receiving virtually no funding to provide services to them (341).

Health Canada must account to Treasury Board (and by proxy to Canadians) on its spending, including how the money transferred to First Nations within the context of the HTP, is being used. It cannot do this very well however because it has very little information on whether or not the HTP is improving health outcomes. First Nations have, in this process, become responsible for accounting to Health Canada on how they spend their dollars, thereby defeating the primary concept of the HTP that sees ultimate responsibility for health care in the hands of First Nations. Lavoie's argument further demonstrates that accountability is not even truly present within First Nations since the HTP does not allow First Nations leaders to properly serve their members. The accountability chain is therefore broken in numerous places due to the way in which the HTP was conceptualized and implemented.

## **Conclusion**

It is not possible to determine at this time if the federal government's Health Transfer Policy has had any direct impact on improving health outcomes among First Nations communities. There are certainly advantages to the federal government's Health Transfer

Policy, including a better ability to establish and manage the unique types of health care services and programs needed in individual communities. The benefits are amplified when considered in the light of Chandler and Lalonde's theory linking increases in self-determination and cultural continuity with increases in health status. There are, however, some disadvantages as well, the most damaging having to do with funding formulas and gaps in jurisdictional responsibility.

While FNIHB-Health Canada can take immediate steps to remedy problems with the funding formulas, more work must be done to better integrate services covered by Health Canada with services covered by INAC and other federal departments. I am encouraged by recent negotiations made in certain provinces, namely Manitoba, Saskatchewan and British Columbia, to repair the fragmentation of services between federal and provincial jurisdiction and to better include the newer level of Aboriginal jurisdiction. Specifically, the intergovernmental committees established in these provinces can make large strides in building relationships and bridging jurisdictional gaps.

A final conclusion to this analysis is that public policy often finds itself at a crossroads where values we may find equally important are actually in tension with one another. In this case, accountability (around performance measurement) and decentralization, two values which we hope bring about better services to all Canadians, actually work against each other as First Nations attempt to assert self-government in the area of health care and the federal government works to relinquish its control. There is of course no easy solution to reconcile these two values, either for the specific issue at hand, or regarding the wider role of government, but as we create, critique and improve public policy, we should consider the tensions that may arise between the various ideals we prioritize. Since it can be difficult to reconcile such tensions, we should strive to assemble strong bodies of evidence on which we can found policy and verify performance. With that in mind, I eagerly await the findings from the RHS's most recent phase of data collection with the hope that more conclusive quantitative data will demonstrate a positive correlation between self-government and health outcomes.

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