3.4: History of the Health Care System in Indigenous Communities

In the spirit and intent of treaty negotiations, the Indigenous people negotiated access to both “medicines” and “medical expertise needed to deal with new diseases” included in the Treaty 6 medicine chest clause to supply all that was required to maintain proper health (Office of the Treaty Commissioner, 2000). The federal government is responsible for supplying and maintaining health services for First Nations. Since the time of the treaties, these “medicines” have included Indian hospitals, medicine, doctors, examinations and treatment of the sick, x-rays, and medical technology.

Historically, relationships between Indigenous people and settler society have been characterized by a number of negative experiences and the two societies developed separately from one another. For the majority of Canadians, health care services are guaranteed by the Canada Health Act and provincial legislation. Indigenous people can access the same services but to differing extents.

In 1989, the National Health and Welfare and Treasury Board of Canada started work toward the transfer of health services for Indigenous communities from the federal to the community level. The transfer of health services is an administrative mechanism that shifts delivery of financial resources from the First Nations and Inuit Health Branch (FNIHB) to Indigenous communities for a select number of health programs. This health transfer supports Indigenous communities in exercising a higher level of governance over their community health care system and lobbying for change as required in the health system.

The goals and objectives of the health transfer policy were:

- to provide Indigenous people opportunities to become actively engaged in planning, administration, and delivery of on-reserve health care services, policy planning, and research;
- to improve health for Indigenous people;
- to ensure Indigenous people have the same quality of seamless care as the rest of Canadians;
- to enable communities to design health programs, establish services, and allocate funds according to community
health priorities;
• to strengthen and enhance accountability of leaders to their members; and
• to ensure public health and safety are maintained through adherence to mandatory programs. (National Health and Welfare & Treasury Board of Canada, 1989; Smith & Lavoie, 2008)

The following table describes models of service delivery provided through a contribution agreement with Health Canada under FNIHB.

Table 3.3.1 Models of Health Service Delivery *(Data source: Table based on material from Lavoie et al., 2005.)*

<table>
<thead>
<tr>
<th>Transferred Community</th>
<th>Integrated Communities</th>
<th>FNIHB–Controlled Community</th>
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<tbody>
<tr>
<td>• Transferred public health programs are delivered at the community level or by Tribal Council.</td>
<td>• FNIHB provides non-transferable programs.</td>
<td>• FNIHB delivers non-transferable public health programs to communities.</td>
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<tr>
<td>• Financial accountability is the responsibility of the community or Tribal Council.</td>
<td>• FNIHB provides semi-transfer of public health programs.</td>
<td>• FNIHB delivers second- and third-level health programs directly to communities.</td>
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<td>• Five-year funding is provided for programs.</td>
<td>• Communities can hire their own nurses.</td>
<td>• FNIHB provides policy and specialty health services.</td>
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<td>• The public health programs are guided by: (1) a transfer implementation framework; (2) a community health plan; and (3) an evaluation plan.</td>
<td></td>
<td>• FNIHB allocates nursing staff.</td>
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The table above outlines the differences between the health care delivery systems that the communities may choose to adopt based on a community’s readiness, needs, and evaluation recommendations. This permits them to meet the changing health trends at the community level.

The community I work under is a fully transferred community, therefore the community delivers the following programs at the community level and some services are delivered by second- or third-level support:

• community health programs (health promotion and prevention)
• Community Primary Care
• communicable disease control and surveillance programs (Northern Intertribal Health Authority, third-level support)
• community immunization programs
• Environmental Public Health Program (Tribal Council, second-level support)
• National Native Alcohol and Drug Abuse Program (NNADAP) and
• Home and Community Care Program (semi-transferred)

Community-based services are delivered in the community by nurses and community health representatives, which includes addiction workers and maternal child care workers. Environmental health services are supplemented by environmental health officers at the second level of organization (Tribal Council) and are supported by the third level of organization (the health region or province).
The transferred community service delivery model is guided by the transfer implementation framework, which outlines how the services are to be delivered and evaluated. Communities follow a strict reporting criterion before funding is released, as outlined in the FNIHB’s contribution agreements documents. Provision of health services for the integrated delivery model differs significantly from the transferred community model and was approved in 1994 under separate Treasury Board authorities. An integrated model is understood as a step toward the full transfer model. Communities can select a range of community-based programs under a single contribution agreement that can be up to five years in length. Funding is based on community work plans and the community or Tribal Council must seek permission from FNIHB to make changes. The carry-over of funds is not allowed and any unspent funding must be send back.

FNIHB has a fiduciary responsibility (a legal duty to act for the benefit of the community) and is accountable for the overall health delivery system for people living on a reserve, a First Nations community. The National Treasury Board transfers money to the region to ensure the health needs of every Indigenous person is addressed. Today, FNIHB continues to monitor the quality of service delivery by First Nations communities to ensure adherence to contribution agreements. The type of health funding found in each community depends on the particular facility designation; these include: health office, health station, health centre, health centre with treatment, or nursing station. Each designation is differentiated by the type and scope of services it delivers. This is an ongoing concern for some communities since it affects the level of funding an organization can access.

From the Field

For me, as an Indigenous nurse leader working in an Indigenous community, it is critical to teach new nurses about the complexity of the service delivery model and to build their awareness of the historical events that form the basis of the present negative stereotypes and racial attitudes about Indigenous people. Many advances have occurred to build positive relationships within the system.

—Norma Rabbitskin, RN, BN

For further information on the history of health and disease patterns of Indigenous peoples in Canada, see Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives (2006) by Waldram, Herring, and Young or learn more on the Evaluation of the First Nations and Inuit Health Transfer Policy (2004) by Lavoie et al.