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Comparing Federal Indigenous Health Policy Reform in Canada and the United States: The Shift to Indigenous Self-Determination in Health Care

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Abstract

Federal governments in Canada and the United States have followed similar timelines and events in their efforts to support Indigenous self-determination in health care. Since colonization, both settler colonies have aimed to assimilate Indigenous Peoples into settler society, in disregard of inherent Indigenous self-determining rights and titles. By the 1970s their policy agendas shifted towards Indigenous self-determination, including in matters of health service planning and delivery at the community-level. This paper analyzes this shift in policy from a comparative perspective with the aim of informing future reforms. We identify and examine the policy instruments used in the process, finding a greater use of regulatory instruments in the United States, compared to informative tools in Canada. We also discuss the associated impacts of the reform on the ability to practice self-determining activities within communities, highlighting some of the administrative enablers and barriers within and around health care settings. As little research has compared health policy reforms related to matters of Indigenous health in Canada and the United States, this paper provides new insights into the drivers and nature of the policy shift toward self-determination at the federal level and suggests grounds for further investigation.

Les gouvernements fédéraux du Canada et des États-Unis ont suivi des chemins parallèles dans leurs efforts pour soutenir l'auto-détermination autochtone en santé. Ces deux colonies de peuplement ont tenté dès l'aube de la colonisation d'assimiler les Peuples Autochtones dans la société des colons, sans égard pour les droits et acquis inhérents aux Autochtones. À partir des années 1970, le discours politique s'est infléchi vers l'auto-détermination autochtone, y compris en matière de planification et de prestation des services de santé au niveau communautaire. Cet article analyse cette inflexion de politique à partir d'une perspective comparative, avec pour objectif de renseigner les efforts futurs de réformes. Nous avons identifié et examiné les outils politiques utilisé dans ce processus, montrant une utilisation plus importante des outils de régulation aux États-Unis alors que le Canada recourait plutôt aux outils d'information. Nous discutons aussi les effets de cette réforme sur la capacité à pratiquer des activités auto-déterminées au sein des communautés, dévoilant certains des facilitateurs et barrières au sein et autour des établissements de soins. Sachant que la recherche comparative sur les politiques de santé autochtone au Canada et aux États-Unis est peu abondante, cet article apporte des éclairages nouveaux sur les facteurs et la nature de l'inflexion politique fédérale en direction de l'auto-détermination et suggère des pistes de recherche future.

Key Messages

- Community-based and informed policy approaches to support and sustain Indigenous self-determination in health care are fundamental to ensuring health service access and effective health service planning in First Nations and American Indian/Alaska Natives communities in Canada and the United States.
- Federal governments in Canada and the United States adopted Indigenous self-determination onto their policy agendas at similar times in response to similar historic and sociopolitical events.
- In their federal health policy shifts towards Indigenous self-determination, the United States employed a greater use of regulatory and litigative instruments with an aim to improve health outcomes of American Indian/Alaska Natives Peoples; while Canada used more informative tools primarily in efforts to restore or build relationships with First Nations Peoples.
- Despite differing policy instruments and goals, Indigenous communities in both countries continue to face administrative barriers to practising self-determining activities within their health care settings, such as limited capacity for health planning and insufficient funds.
- There is room for much improvement to the current efforts to support Indigenous self-determination in federal health policy across Canada and the United States; further research informed by the lived experiences of policy impacts is required to advance this work.

Messages-clés

- *Les approches de politique éclairée et fondée dans la communauté pour soutenir et maintenir la détermination en santé autochtone sont essentielles pour assurer l'accès aux services de soins et une planification efficace des services de soins pour les communautés des premières nations et des American Indians/Natifs de l'Alaska, au Canada et aux États-Unis.*
- *Les gouvernements fédéraux au Canada et aux États-Unis ont adopté l'auto-détermination autochtone dans leur discours politique au même moment, en réponse à des événements historiques et socio-politiques similaires.*
- *Au cours de cette inflexion de la politique de santé fédérale vers l'auto-détermination autochtone, les États-Unis ont fait un plus grand usage des outils de régulation et de réglementation, avec pour but d'améliorer les résultats de santé des American Indian/Natifs de l'Alaska; pendant ce temps, le Canada utilisait plutôt des outils d'information dans ses efforts pour restaurer ou construire des relations avec les Premières Nations.*
- *En dépit d'outils politiques et d'objectifs différents, les communautés autochtones des deux pays continuent à faire face à des barrières administrative pour pratiquer des activités auto-déterminées dans leurs établissements de santé, comme la capacité limitée de planification sanitaire ou des fonds insuffisants.*
- *Il est possible d'améliorer les efforts présents pour soutenir l'auto-détermination autochtone dans les politiques fédérales de santé au Canada et aux États-Unis; plus de recherche informée par l'expérience vécue et l'analyse des effets des effets des politiques est nécessaire pour accompagner cet effort.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Federal governments in Canada and the United States have sought to advance self-determining activities in health care in First Nations and American Indian/Alaska Natives (AIAN) communities. This support for Indigenous self-determination represented a gradual shift in policy since the mid-1970s, as policy goals changed from cultural assimilation of Indigenous Peoples into settler society, toward uplifting and building capacity within Indigenous communities (Kelly 2011; Warne 2011). The latter continues to shape decision and policy-making practices in Indigenous health care today. This study analyzes this shift in policy from a comparative perspective across the two countries with the aim of informing future reforms.

Before diving deeper into the reform, a note on population demographics may be of use for context. The Indigenous population in Canada is constitutionally recognized as including First Nations, Inuit, and Métis peoples (*Constitution Act*, 1982). In 2016, more than 1.67 million people in Canada self-identified as Indigenous, representing up to 4.9% of the total population (Indigenous Services Canada 2020a). Indigenous Peoples live all across the country, the majority in urban areas. There are more than 600 First Nation communities across Canada, with up to 40% of people identifying as First Nations living in these areas (Indigenous Services Canada 2020a). Although all First Nations, Inuit, and Métis peoples have a fiduciary relationship with the federal government, for the purpose of narrowing the scope, this study focuses on First Nations peoples only.

In the United States, approximately 5.7 million people self-identify as American Indian or Alaska Native, representing 1.7% of the total population (U.S. Department of Health and Human Services 2022). The majority of AIANs live in urban areas, primarily in 10 of the 50 states: Arizona, California, Oklahoma, New Mexico, Texas, North Carolina, Alaska, Washington, South Dakota, and New York. There are 574 federally recognized tribes, with up to 22% of the AIAN population living in these areas (U.S. Department of Health and Human Services 2022). Both the American Indian and Alaska Native populations are within the scope of this paper.

1.1 Similar Sociopolitical Histories and Relationships

Both Canada and the United States are settler colonies, and as such share similar sociopolitical histories and relations with Indigenous Peoples (Mashford-Pringle 2011). Federal governments in both countries are responsible for the delivery of health care to First Nations Peoples in Canada, and AIANs in the United States, bounded by treaty, trust, and legislative agreements (Lavoie 2013; Warne and Frizzell 2014). In Canada, the federal government's responsibility is based on Section 91(24) of the *Constitution Act* (1867) and Treaty 6 (1876) (Webb 2021). Provisions within this Act and Treaty hold the federal government accountable for health care and other services in First Nations communities

(Lavoie 2013; Lavoie et al. 2015). In the United States, the federal government is similarly held accountable for health care service provision for AIANs based on Article 1, Section 8 of the 1787 Constitution of the United States (Indian Health Service n.d.(a)). As such, AIANs peoples are the only population within the United States to be entitled to federally funded health care (Warne 2007). Both Canada and the United States are also responsible for engaging in and respecting land claim negotiations to support First Nations and AIANs communities in the uptake of health care administration and control of delivery for their communities. This process is also codified, specifically in the Comprehensive Land Claims Policy in Canada (Aboriginal Affairs and Northern Development Canada 2014) and the *Alaska Native Claims Settlement Act* in the United States (ANCSA Regional Association n.d.). Although treaty negotiations fall outside the scope of this paper, they represent an important mechanism to support Indigenous self-determination in health care, and therefore may be considered for future research and analysis.

Furthermore, Canada and the United States have in common the historical and ongoing discrimination and systemic racism within health care settings, which has given rise to current health inequities disproportionately affecting Indigenous Peoples across both countries (Phillips-Beck et al. 2020; Garoutte et al. 2008; Kramer and Weller 1988). As self-determination is a fundamental determinant of Indigenous health and well-being (Reading and Wien, 2009), the shift in policy in the two countries represents an opportunity to inform sustainable, long-term solutions to improving health outcomes.

The transition from assimilation to self-determination at the federal level in Canada and the United States was initiated in response to Indigenous-led and ally-supported retaliation against assimilation. In the 1960-70s, anti-Indigenous racist policies were met with resistance from national Indigenous organizations and allies, forcing governments on both sides of the border to make a policy shift. Canada was explicit in its goal to restore relationships with Indigenous Peoples through reform; meanwhile in the United States, the federal government and stakeholders placed less emphasis on relationships, and focused more on improving health outcomes within AIANs communities as drivers to the reform (Kelly 2011; Gurr 2013). The push and pull between federal and Indigenous leaders gradually led to Indigenous self-determination taking a more prominent role at the policy table.

There are two contrasting arguments in the literature about the implicit goals of this policy shift. Some scholars suggest federal efforts to entrench self-determination in policy is the federal government's commitment to Indigenous sovereignty and recognition of inherent Indigenous rights to self-determining and self-governing activities (Gurr 2013; Kelly 2011). Others argue this policy shift was the federal government's attempt to avoid its fiduciary responsibility to provide services and resources to Indigenous Peoples, and to offload its responsibilities on to Indigenous communities themselves (Skinner 2015; Thierry et al. 2009; Jacklin 2008).

In health care, self-determining activities refer to the ability to exercise authority, participate in decision-making practices, possess control over health, and to play an active role in health service planning, design, and delivery (Reading and Wien 2009; Mashford-Pringle

2013; 2016). Moreover, self-determination means health systems and reforms are designed by and for Indigenous Peoples according to community needs, enabling the dismantling of colonial structures that constitute current models of health care. Canadian and American mainstream health care systems are currently dominated by settler culture and lack culturally appropriate and safe care for Indigenous Peoples (Thurston and Mashford-Pringle 2015; Turpel-Lafond 2020). While the past few decades have seen a shift toward self-determination in health policy in Canada and the United States, policy action has stalled. This analysis of the past policy shift in the two countries may help inform future efforts to sustain attention and implement policies in support of self-determination.

2 HISTORY AND CONTEXT

There are parallel timelines in North American policy development after the Royal Proclamation (1763), Canada signed Treaty 6 (1876), and the United States signed the Ottawa/Ojibwe Treaty (1836). The Royal Proclamation set the stage for treaty negotiations, with Treaty 6 and the Ottawa/Ojibwe Treaty being the first treaties to exchange land for federally funded health and social services. While there were treaties and agreements prior to these two treaties, the significance of including health and social services (e.g., education) are important for the current health inequities experienced by Indigenous Peoples in both countries.

Table 1 (below) lists key policies in eras of assimilation and self-determination for First Nations and AIANs Peoples. Appendix 1 provides more information on each of these policies.

In Canada and the United States, assimilation was preceded by an era of extermination of Indigenous lands, titles, and communities, with policies such as the Doctrine of Discovery governing the process (Reid 2010). The Doctrine of Discovery was an illegitimate legal tool used by colonizers to claim land upon discovery, regardless of its previous ownership or title (Reid 2010). Following the establishment of the dominion of Canada, extermination slowly shifted into assimilation of Indigenous Peoples to "blend" into settler society (Mashford-Pringle 2011). The era of assimilation is largely marked by the *Gradual Civilization Act* (1857), as it established the definition of "Indian" and was the prercursor to the *Indian Act* (1876) (Lavallee and Poole 2010). Together the *Gradual Civilization Act* and the *Indian Act* imposed genocidal regulations including the instalment of federal Indian Residential Schools (1880s-1996) (McMahon 2017; Lavallee and Poole 2010). In the United States, the *Civilization Act* (1819) and *Indian Citizenship Act* (1924) played key roles in both extermination and forced assimilation of AIANs Peoples (Mashford-Pringle 2011).[1] Since colonization, First Nations, Inuit, and Métis Peoples in Canada, and AIANs in the United States were considered uncivilized peoples in need of settler-induced civilization, ignorantly

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[1] For further details on events including descriptive histories of the *Indian Act*, Indian Residential Schools, the *Civilization Act*, and the *Indian Citizenship Act*, see Mashford-Pringle 2011.

justifying grounds for governments to ban and eradicate traditional Indigenous cultures, languages, and governance structures (McMahon 2017; Mashford-Pringle 2011). This era of policy is described as cultural genocide (Truth and Reconciliation Commission of Canada 2015). By the 1970s, the Canadian and American federal governments proposed further attempts at forced assimilation—the White Paper in Canada (1969), and the Termination Policy, resultant of the House Concurrent Resolution 108 (1953) in the United States. Both were met with Indigenous and ally retaliation and political advocacy ultimately reducing assimilation and promoting the shift to self-determination onto the policy agenda.

Table 1: Canada and the United States Federal Indigenous Health Policy Timelines

CANADA	UNITED STATES
Treaties and Federal Responsibilities for Health Care Delivery	
Royal Proclamation, **1763**	Royal Proclamation, **1763**
Treaty 6, Medicine Chest Clause, **1876**	U.S. and Ottawa/Ojibwe Treaty, **1836**
Cultural Assimilation and Discriminatory Policies	
Indian Act, **1876**	Civilization Act, **1819**
Hawthorne Report, **1961**, White Paper, **1969**	House Concurrent Resolution 108, **1953**
Self-Determination and Building Community Capacity Policies	
Community Health Representatives, **1970**	Community Health Medic Training Program, **1970**
Indian Health Policy, **1979**	Indian Health Care Improvement Act, **1976**
Health Transfer Policy, **1986**	Indian Self-Determination Education Assistance Act, **1975**
Health Transition Fund, **1997**	Prevention and Public Health Fund, **2010**
Aboriginal Diabetes Initiative, **1999**	Special Diabetes Program for Indians, **1997**
Medical Transportation Policy, **2005**	Purchased/Referred Care Program, **1991**
United Nations Declaration on the Rights of Indigenous Peoples, **2010**	United Nations Declaration on the Rights of Indigenous Peoples, **2007**

In Canada, the White Paper (1969) was released by the Liberal government, in response to a national study on health service access for First Nations in Canada completed by Booz, Allen & Hamilton Canada Ltd (1969) (Health Canada 2006). The study found the federal government was not meeting its fiduciary responsibilities to First Nations peoples, and that "the [First Nations] health programs delivered on reserve were broad in scope but failed to involve [First Nations] in the planning and evaluation of programs" (Booz, Allen & Hamilton Canada Ltd, 1969, as cited in Health Canada 2006, p. 36). Booz, Allen, & Hamilton Canada Ltd (1969) made several recommendations based on their findings, some rooted in Indigenous self-determination, such as the recommendation to increase community participation in the delivery of health care services (Health Canada 2006). Despite these recommendations, the Liberal government responded with the White Paper (1969) and proposed to equalize Indigenous and non-Indigenous populations, by abolishing the *Indian Act* and with it, First Nations-status, and entitlement to Indigenous Treaty and land rights (Weaver 1981). This final attempt to assimilate Indigenous Peoples into settler society was met with the Red Paper (1970), released by the National Indian Brotherhood (now Assembly of First Nations). The Red Paper defended Indigenous rights and advocated for the need to promote and support Indigenous self-determination, calling on the federal government to uphold its treaty obligations and agreements (Kelly 2011). Due to the strength of the political pushback and advocacy from First Nations leadership, and support received by the general public, the Liberal government responded by withdrawing the White Paper and adopting the Red Paper in principle to spearhead a new era of Indigenous health policy-making towards self-determination (Kelly 2011).

The United States had a similar path to AIAN self-determination in health policy. The House Concurrent Resolution 108 was passed by the United States House of Representatives and Senate in 1953, otherwise known as the "termination policy" (Thierry et al. 2009, p. 1544; Gurr 2013, p. 74). The federal termination policy was the United States' final attempt to end its fiduciary relationship with AIAN Peoples, and to fully integrate AIAN people into settler society (Gurr 2013). The termination policy initiated a series of policies that ended federally funded services to over one hundred AIAN tribes, stripped AIANs of their treaty and land rights, and forcibly removed AIANs off tribal land (Gurr 2013; Thierry et al. 2009). The termination policies came to a halt after President Nixon released a landmark address to Congress, entrenching AIAN "self-determination without termination" into federal policy (Nixon 1970, p. 1). In his address, President Nixon described the termination policies as morally and structurally wrong, stating the policies dishonoured and contradicted historical treaty agreements and trust relationships between the United States government and AIAN tribes. President Nixon's speech influenced a new era in federal policy, stating:

> Self-determination among the Indian people can and must be encouraged without the threat of eventual termination…that is the only way that self-determination can effectively be fostered. This, then, must be the goal of any new national policy toward the Indian people to strengthen the Indian's sense of autonomy without threatening this sense of community (Nixon 1970, p.2).

Policy analysts suggest this call for improved tribal self-determination was heavily influenced by the American Indian Movement (AIM), active in the United States from 1968 into the early 1970s (Blendon and Benson 2001; Willging et al. 2012; Warne and Frizzell 2014; Davey 2021). The AIM was led by the advocacy work of AIANs Peoples, communities, and allies demanding fundamental legislative changes to end impoverished conditions, restore legal rights, and reclaim tribal lands to give to AIAN Peoples (Davey 2021). Together President Nixon's address, and the AIM directed the United States' adoption of AIAN self-determination in federal policy, and the political shift from assimilation.

3 THE POLICY-MAKING PROCESS

We draw on the Bemelmans-Videc et al. (1998) categorization of policy instruments—*1*) regulation (sticks); *2*) economic means, such as taxes and financial incentives (carrots); and *3*) information (sermons)—to describe and compare key factors influencing Canada's and the United States' federal health policy reform in support of Indigenous self-determination. We also explore the concepts of ideas and institutions to shed light on some of the reasons for the choice of policy instruments in the two countries.

The methods we used to identify and analyze health policies from Canada and the United States are described in Webb (2021). In brief, we completed a scoping review of both grey and academic literature, searching a variety of databases such as PAIS Index, Sociological Abstracts, Native Health Database, Government of Canada Publications, and other institutional websites from federal government and Indigenous organizations. Sources were included if they addressed First Nations and/or AIANs communities; focused on federal-level health policy; and mentioned impacts on access to care, including impacts on self-determination. In determining a policy's impact on, or relevance to Indigenous self-determination in health care, we used the Davy et al. (2016) accessibility framework. Within this framework, we inferred potential effects on self-determination if a factor, such as a policy or law, impacts the ability to make decisions regarding an individual and/or community's health care and/or plays an active role in health service planning and delivery (Davy et al. 2016; Webb 2021). We then extracted the mentioned health policies from the literature and categorized each based on its most applicable use of policy instrument according to Bemelmans-Videc et al. (1998) typology. Three validation interviews with health policy experts who study Indigenous health and policy were also held to discuss and validate the findings.

The scoping review yielded a total of 57 literature sources, and of this total, identified 30 federal Indigenous health policies in Canada, 16 of which were deemed relevant to self-determination, and 23 federal Indigenous health policies in the United States, 12 of which contained relevance to self-determination. The United States was found to exercise a much greater use of regulatory instruments compared to Canada, which primarily used informative tools to support self-determining activities in health care. Specifically, nine out of 16 policies in Canada that were associated with Indigenous self-determination in health care are strategy documents without any regulatory or financial component, with only three that are regulatory. By contrast, in the United States, six out of the 12 policies are legislation or regulations, and only one policy uses informative means. Economic instruments are used to a similar degree in each country (four policies in Canada, five policies in the United States).

Table 2 summarizes these differences in the use of policy instruments, showing the number of policies found in each country that use regulatory, economic, or informative tools in influencing Indigenous self-determination in health care. Appendices 2-3 list all relevant policies that were reviewed and included in our study, categorized according to the policy framework.

Table 2: Canada and the United States: Number of Policies Associated with Indigenous Self-Determination in Health Care and their Use of Policy Instruments

	REGULATION	ECONOMIC TOOLS	INFORMATION
Canada	3	4	9
United States	6	5	1

As noted above, Canada and the United States introduced policies in support of Indigenous self-determination in the 1970s. At the beginning of this period, both countries introduced similar programs in the year 1970—the Community Health Representatives Program in Canada and the Community Health Medic Training Program in the United States. Each program was designed to build community capacity and to ensure federal resources were allocated directly to FNs and AIANs communities in the process. Shortly after, specific policies to support the reform were released, largely due to the role of political advocacy stemming from First Nations and AIANs leadership, communities, and Indigenous organizations, as described above (see Section 2: History and Context). The United States federal government legislated its commitment for tribal self-determination through the *Indian Health Care Improvement Act* (1976). In Canada, the 1979 Indian Health Policy was published, and used informative means to document the federal government's goals to advance First Nations community capacity and Canada's health care system regarding Indigenous health (Crombie 1979).

We posit two possible explanations for the differing use of regulatory and informative policy instruments. First, the greater reliance on regulatory instruments in the United States than in Canada may relate in part to different political institutions. The presidential system in the United States generally leads to greater use of legislation than a parliamentary system, because of the separation of powers between executive and legislative branches of government and divided legislature into the House of Representatives and the Senate. Regardless of the policy issue or arena, legislative decisions are negotiated between the Senate and House of Representatives at the federal level. This structure is replicated at the state level. This environment may favour the adoption of clear and precise rules and guidelines: informative tools without legislation are less likely to be passed in this system than in a parliamentary system. Moreover, in Canada, there is overlapping responsibility for health care for Indigenous Peoples: the federal government funds health services on First Nations reserves, while provincial/territorial universal health coverage programs must include all Indigenous Peoples residing in the province/territory. The decentralization of Canada's federation and overlapping and unclear division of responsibility across federal and provincial/territorial governments makes legislation specifically in areas of health less likely to be passed at the federal level, as it must be transferrable and flexible to accommodate provincial and territorial jurisdiction and authority in matters of health (Lavoie 2013; Lemchuk-Favel and Jock 2013; Abele 2004; Royal Commission on Aboriginal Peoples

1996). Thus, federal policies with loosely structured guidelines (e.g., informative measures) are more often the result in Canada.

The second possible explanation for the differences in policy instruments may attribute to differing cultures of solidarity between the two countries (J. Lavoie, personal communication, 16 September 2020, as cited in Webb 2021). Canada tends to be more relational—meaning it tends to focus on establishing and restoring relationships through policy (J. Lavoie, personal communication, 16 September 2020, as cited in Webb 2021)—than the United States, as reflected in national values attached to Canada's universal health coverage system. Tuohy (2018) describes Medicare as part of the "national identity" of Canada that reflects a "sharing community" (p. 12). This sense of social solidarity translates into policy-making practices in Canada, as policies are often the outcome of relationships and reaching mutual understandings and agreements. The Indian Health Policy, Royal Commission of Aboriginal Peoples (RCAP) and the Truth and Reconciliation Commission (TRC) are all examples of processes and policies that promote Indigenous self-determination and have emerged from discussions focusing on restoring relationships with Indigenous Peoples. For example, the RCAP committed the federal government to a new relationship with Indigenous communities, with distinct priority areas and recommendations to build capacity in communities and improve Indigenous health status across the country (Kelly 2011; Royal Commission on Aboriginal Peoples 1996); however, it does not involve legislative or regulatory change.

In comparison to Canada, the United States is less focused on building or restoring relationships through policy, and rather takes a more litigative approach to Indigenous health policy-making. This litigative approach may relate in part to the idea of health as an individual responsibility, and health care as a private market. The privatization of health care in the United States attests to the country's idea of itself as a corporatist society. Health care is thought to be an individual right, and policy decisions are made from the point of maximizing profits, as opposed to building relationships (Frerichs et al. 2019; Schneider 2005). Nevertheless, relationship-building with AIANs communities still holds some purpose in United States legislation. For example, the 2010 *Indian Health Care Improvement Act* includes provisions to strengthen communicative relationships between federal and tribal governments (Warne et al. 2017), in order to achieve the first and primary goal "to ensure the highest possible health status of [AIANs] and to provide all resources necessary to effect that policy" (*Indian Health Care Improvement Act* of 2011, 25 U.S.C. § 1601.). The Act thus places emphasis on improvements to health outcomes and securement of the appropriate means to do so, while building relationships between tribal and federal governments is a secondary measure enabled by the Act as a result of working towards policy goals. Explicit commitments to build or restore relationships, as in the RCAP and TRC in Canada, do not play as significant a role in informing policy in the United States. While we observed differences in policy instruments used, the impact of these differences on the policy goal of self-determination is unclear.

4 IMPLEMENTATION AND EVALUATION

The implementation and evaluation of the policy shift toward self-determination in the two countries has focused largely on two specific policy changes: the Health Transfer Policy (HTP) in Canada, and the *Indian Self-Determination Education Assistance Act* (ISDEAA) in the United States. Both policies were the first federal policies to lead to tangible outcomes for First Nations and AIANs communities in terms of their autonomy and participation in the health care delivery process. The HTP and ISDEAA remain active today and continue to play fundamental roles in community-based health care administration.

The HTP and the ISDEAA are both designed for communities to assume some level of control over health services and to tailor programs according to community-based needs and culturally appropriate practices (Smith and Lavoie 2008; Warne 2011; Shelton et al. 1998). In Canada, eligible communities may enrol with the HTP and take on various forms of leadership in health care planning, design, and/or delivery. For First Nations communities, this means being south of the 60th parallel (the mainland boundary spanning the southern borders of the three territories, separating them from the western and prairie provinces of Canada), having sufficient leadership (as determined by Health Canada and Indigenous Services Canada), developing the health plan, and ensuring that programs and services can be delivered in the location (Mashford-Pringle 2013). Although, the HTP funding formulas pose a significant barrier to adequate and modern delivery of care, as funding levels continue to be based on historical expenditures and most HTP agreements have a no-escalation clause (Lavoie, Forget, O'Neil 2007; Smith and Lavoie 2008). This method of funding formulas often fails to adjust to changing community demographics and needs (Lavoie, Forget, O'Neil 2007; Smith and Lavoie 2008). Research suggests that as the population grows and residents are living longer, with increasingly complex and financially-demanding chronic disease, communities receive inadequate funding to deliver appropriate services, and health programs funded in community do not always align with community needs (Smith and Lavoie 2008; Kyoon-Achan et al. 2021). Moreover, the HTP and its related mandatory health programming is designed and developed without First Nations consultation, nor input on necessary services. Thus, First Nations communities may gain community control over health services that are designed by the federal government, which may or may not pertain to their needs, and/or receive inadequate financial support to deliver programs in alignment with the communities' cultural practices or preferences (Smith and Lavoie 2008).

Similar arguments pertain to the federal Non-Insured Health Benefits Program (NIHB) in Canada, adjacent to the HTP. The NIHB is a supplementary health insurance program for Indigenous Peoples in Canada, funded by the federal government. Within the NIHB directives Indigenous Peoples are encouraged to enrol and take control of managing their own health care, however, the directives are characterized by heavy federal control and minimally structured administrative processes to facilitate clear transfers of essential resources to receive care (Brooks, Darroch, Giles 2013; G. Marchildon, personal communication, 23

September 2020 as cited in Webb 2021). The limited space allotted to consultation or engagement with First Nations at the community-level continues to operate today. For example, in Canada's current efforts to develop distinctions-based Indigenous health legislation, aimed to "improve access to high-quality, culturally relevant health services" (Indigenous Services Canada, 2022, p. 1), the federal government has arranged for engagement activities with Indigenous leadership and organizations at regional and national levels. Yet, organized engagement activities at the local level to ensure voices are heard directly from communities is missing. In summary, critiques of Canada's federal policy efforts to support Indigenous self-determination reveal the reality of the many financial, design, and administrative barriers.

The ISDEAA in the United States has a specific provision that has helped to minimize the aforementioned financial and administrative obstacles that are faced in Canada, suggesting an effective route to supporting AIAN self-determination in health care (Warne and Frizzell 2014). Under title 5 of the ISDEAA, tribal communities may opt into a funding agreement known as the "638 compact." The "638 compact" instills allocations of the total Indian Health Service budget (the federal department responsible for the delivery of care in AIAN communities) to tribal communities, allowing greater reliability of funds, community-control, and flexibility in the planning of health programs and resource allocation (Warne and Frizzell 2014). This process enables AIAN communities to better design and deliver services specific to changing community-based needs (Warne and Frizzell 2014); thereby differing from the more structured approach offering little flexibility to health program planning under the HTP in Canada. With the ISDEAA, tribal communities may thus independently assume full control over health service planning, delivery, and funding, with little intrusion from the federal government (D. Warne, personal communication, 27 August, 2020, as cited in Webb 2021).

As the HTP in Canada is not protected by legislation nor guided by specific regulations, it does not guarantee a specific level of funding or high degree of flexibility in health service or program planning as observed by the ISDEAA. Rather, the greatest degree in transfer of control to support Indigenous self-determination within the HTP allows communities to administer health programs specific to their priorities, so long as programs align with a pre-established 3- to 5-year plan and mandatory services developed by the Canadian federal government are provided (i.e., immunization, communicable disease control, and environmental health programs) (Lavoie et al. 2010). Of particular concern, mental health services, traditional Indigenous healing practices, and other specialty services such as occupational or speech therapies are not funded by the HTP, regardless of need expressed by communities (Smith and Lavoie 2008; Kyoon-Achan et al. 2021). Whereas under the ISDEAA, tribal communities assume full control and authority to deliver these services if need exists (Warne 2011). Shelton et al. (1998) completed an evaluation of the ISDEAA from the perspective of health care professionals and service providers. Their work revealed improvements in not only tribal sovereignty and control over health care, but also evidence of improved health care quality, and an expansion of available services directly in tribal communities (Shelton et al. 1998). Although the HTP and ISDEAA share numerous similarities in their opportunities and objectives, distinct differences may translate into differing health and self-determining outcomes. To our knowledge no recent evaluative work has studied the direct health or social outcomes of the ISDEAA, thus, it is unknown which policy approach may lead to greater health outcomes or community satisfaction. Future research is recommended to advance this area of knowledge.

5 ANALYTICAL COMPARISON

Despite similar histories and timelines, the policy instruments used in Canada's and the United States' health policy reforms in support of Indigenous self-determination in health care differ, presenting new questions to be explored in further analyses. For instance, further work is needed to investigate the direct impacts of the health policy reforms on self-determining activities on the ground in First Nations and AIANs communities, determined by First Nations' and AIANs' Peoples priorities and giving direct voice to lived experience. Arguably, two of the key policies that marked the shift in policy toward self-determination in the two countries have had different effects due in part to the different policy instruments. Specifically, the *Indian Health Care Improvement Act* (IHCIA) (1976) in the United States continues to impact AIAN health policy in contemporary times, by holding the federal government accountable to support AIAN self-determination. By contrast, the Indian Health Policy in Canada which had a similar goal to the IHCIA, has had a much more limited impact on contemporary health policy, since the commitment to Indigenous self-determination was never legislated, nor were the policy goals of the Indian Health Policy ever supported with an implementation plan (Mashford-Pringle and Webb, in press). Additionally, we recommend investigating if, and to what extent, the relational aspects of the policy-making process in both countries impacts policy implementation and how self-determining activities in health care may be practiced within communities.

Nevertheless, in spite of the differences we observed in policy instruments and policy actors, the experiences of First Nations and AIANs Peoples in terms of inequitable health and access to care persist (Ramraj et al. 2016; Webb 2021). Indigenous Peoples in both countries also continue to plead for greater federal supports to advance and respect self-determination in health care systems and practices (Assembly of First Nations 2017; Jacklin 2008; Henley 2016). What this tells us is that the current policy strategies, regardless of policy instruments used, *are not working*.

As earlier mentioned, the goals of each jurisdiction's reform remain unclear. Whether it is to acknowledge Indigenous Peoples inherent right to self-determination (Gurr 2013; Kelly 2011), or to offload fiduciary responsibilities to local communities (Thierry et al. 2009; Jacklin 2008), an argument can be made that, in any case, federal governments maintain some level of authority and control over Indigenous self-determination in health care. Regardless of the policy instrument, the federal government is in control of the human and financial resources necessary to exercise decision-making and effectively implement strategies to improve or offer new health programs in Indigenous communities (Lavoie et al. 2015; Skinner 2015; Walker et al. 2018; Warne and Frizzell 2014; Government of Canada 1994; Health Canada 2006; Jacklin 2008). The Medical Transportation Policy (MTP) in Canada and Purchased and Referred Care Program (PRC) in the United States are two further policy examples (Government of Canada 2015; King 2012; Warne, Kaur, Perdue 2012). Both are federal policy programs that followed the HTP and ISDEAA, and are tasked to improve First Nations and AIANs physical access to remote care according to individual-based needs (Indian Health Service n.d.(b); Government of Canada 2015); and thus, may also be considered mechanisms to exercise self-determination in care at an individual level. The MTP and PRC both employ economic tools to support policy implementation, as both are financial programs where individuals may apply for travel subsidies to medical appointments (Indian Health Service n.d.(b); Government of Canada 2015). However, as with their predecessors—the HTP and ISDEAA—there are significant barriers to equitable opportunities under the MTP and PRC, stemming from government financial and administrative holds over the programs (Warne, Kaur, Perdue 2012; Government of Canada 2015; Lavoie et al. 2015).

In the United States, equitable access to the PRC program and its associated medical travel benefits is hindered by the program's funding formulas established and regulated by government (King 2012). In King's (2012) evaluation of the PRC, funding formulas were found to not reflect community need, nor accurate representation of PRC service users. Rather, the majority of funding was based on historical expenditures. Supplements are based on annual population growth and inflation, however, with equal distribution across all communities regardless of size or need. Increments are based on all users of the Indian Health Service, not the PRC in particular (King 2012). These funding shortfalls lead to inequitable program access, limited service coverage, and an overwhelming denial rate to inadequate funding levels (Warne, Kaur, Perdue 2012; King 2012).

Similar administrative hurdles exist with respect to the MTP in Canada. Evaluative evidence shows a lack of coordination within its policy directives, minimal funding for speciality services, and insufficient documentation of decision-making practices to approve eligibility amongst applicants, leading to subjective decisions regarding denial or acceptance of the program benefits (Government of Canada 2015). The jurisdictional ambiguities regarding the financing of Indigenous health care between federal and provincial/territorial governments creates further administrative confusion among bureaucrats responsible for screening applicants for the program benefits; and results in delays to receive essential care (Lavoie et al. 2015). Perhaps the most significant hurdle is the federal hold on the decision-making power to implement the policy, rather than enabling decision-making by Indigenous communities, for community members.

With these criticisms in mind, the MTP in Canada is currently undergoing updates by Indigenous Services Canada (federal department responsible for Indigenous health care), with anticipated revisions including expansion of eligible services and the types of care to be funded by the program (Indigenous Services Canada 2020b). However, decision-making practices governing eligibility for and implementation of the MTP program continue to fall under federal jurisdiction, as opposed to implementation through a co-leadership model with participating Indigenous communities or governments. As many evaluations of the MTP point to the need to better align the administrative process with community and individual health care and cultural needs (Government of Canada 2015; Lavoie et al. 2015; Lavoie et al. 2016), perhaps the most obvious improvement to the MTP and other policies associated with Indigenous self-determination, is to take the next steps to fully and authentically support self-determining activities. In both Canada and the United States, this may look like partnerships with federal governments to provide the necessary human and financial resources according to community capacity and available assets, remove time consuming and bureaucratic procedures, and enable Indigenous communities to assume full control of decision-making practices regarding their own, and their communities' health (Gregory et al. 1992; Lavoie et al. 2015).

Little research has compared federal Indigenous health policies between Canada and the United States, as the literature mainly focuses on health outcomes (Kramer and Welle 1988), socio-political histories (Mashford-Pringle 2011) and policy impacts on access to health care services (Webb 2021). To our knowledge, this review is first to track and compare Indigenous health policy reform in support of Indigenous self-determination in health care, thus contributing to a growing body of knowledge, one of great promise and enthusiasm for further policy analysis. While our study provides some new insights into the drivers and nature of policy shift toward self-determination at the federal level in Canada and the United States, lessons to inform future productive reforms will require the knowledge of lived experiences of policy impacts.

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APPENDIX 1. Canada and the United States Federal Indigenous Health Policy Timelines and Document Descriptions

Treaties and Federal Responsibilities for Health Care Delivery

Canada	United States
Royal Proclamation, 1763 Guidelines for European settlement of Indigenous territories in what is now North America. States all land considered Indigenous land until ceded by treaty. Forbids settlers from claiming land from the Indigenous occupants, unless it has been first bought by the Crown and then sold to the settlers.	**Royal Proclamation, 1763** Guidelines for European settlement of Indigenous territories in what is now North America. States all land considered Indigenous land until ceded by treaty. Forbids settlers from claiming land from the Indigenous occupants, unless it has been first bought by the Crown and then sold to the settlers.
Treaty 6, Medicine Chest Clause, 1876 Only historic numbered treaty to exchange land for health services between Indigenous peoples and colonial settlers. Specified federal obligations to signatory FNs peoples with regards to health care.	**U.S. and Ottawa/Ojibwe Treaty, 1836** First treaty to exchange Indian land for health services provided by the federal government.

Cultural Assimilation and Discriminatory Policies

Canada	United States
Indian Act, 1876 Federal policy in attempt to assimilate FNs peoples into western, settler culture. Sparked series of discriminatory policies and bans against Indigenous culture.	**Civilization Act, 1819** Federal commitment to provide essential health services to AIANs peoples to avoid risk of spreading disease. As well, federal government implemented school system in efforts to assimilate AIANs peoples into western, colonial culture.

Hawthorne Report, 1961; White Paper, 1969 • Hawthorne Report: Commissioned by Liberal government. Sought to describe health disparities of FNs peoples. Recommended to assimilate Indigenous peoples in western culture and to leave reserve lands. • White Paper: Official recommendation by the Liberal government to abolish the *Indian Act*, along with treaty, land and Indian status rights.	**House Concurrent Resolution 108, 1953** Beginning of series of termination policies into the 1970s. Objective to remove AIANs from their land, abolishing treaty rights.

Self-Determination and Building Community Capacity Policies

Canada	United States
Community Health Representatives, 1970 Federally funded program to train community members living on-reserve on how to assist in delivering health services alongside registered nurses.	**Community Health Medic Training Program, 1970** Federally funded program to employ and train AIANs community members to work alongside health care professionals in their community to aid in delivering health services.
Indian Health Policy, 1979 Developed by Conservative government, in attempt to rebuild Indigenous-federal government relationships and strengthen community control and the Indigenous health care system.	**Indian Health Care Improvement Act, 1976** Authorized annual appropriations from Congress in support of the Indian Health Service (IHS) and AIANs health care, as well as other implications including Medicaid and Medicare reimbursement for care delivered at IHS and tribal health facilities.
Health Transfer Policy, 1986 Federally funded program, provides opportunity for FNs communities to assume administrative and planning control over health services.	**Indian Self-Determination Education Assistance Act, 1975** Federally funded program for tribal communities to assume health care service planning and delivery roles from or alongside the Indian Health Service.

Health Transition Fund, 1997 Federal funding program active from 1997-2001. Supported 140 projects across Canada to deliver health care services using innovative methods.	**Prevention and Public Health Fund, 2010** Under the *Affordable Care Act*, tribal communities can apply for funding grants designed to support public health programming such as infectious disease and tobacco programs and other community-based services.
Aboriginal Diabetes Initiative, 1999 Federally funded program dedicated to funding diabetes services and education for FNs communities, attempt to reduce rates of diabetes.	**Special Diabetes Program for Indians, 1997** Federally funded program in support of diabetes education, screening and procedures for AIANs peoples, including culturally appropriate services. Attempt to reduce diabetes prevalence.
Medical Transportation Policy, 2005 Federally funded service to transport FNs peoples to receive essential care not available within their community.	**Purchased/Referred Care Program, 1991** Federally funded service to transport AIANs peoples to receive essential care not available within their community.
United Nations Declaration on the Rights of Indigenous Peoples, 2010 Federal agreement to recognize, promote and protect the rights of Indigenous peoples in all its actions.	**United Nations Declaration on the Rights of Indigenous Peoples, 2007** Federal agreement to recognize, promote and protect the rights of Indigenous peoples in all its actions.

APPENDIX 2. List of Canadian Policies Included in This Review, Date of Introduction, and Use of Policy Instrument

POLICY	YEAR	POLICY INSTRUMENT
Royal Proclamation*	1763	Regulation
Hawthorne Report*	1961	Information
White Paper*	1969	Information
Red Paper*	1970	Information
New Federal Gov't Indian Relationship	1976	Information
Indian Health Policy*	1979	Information
Canadian Constitution Act*	1982	Regulation
First Nations Health Networks	1986	Economic Tools
Health Transfer Policy*	1986	Economic Tools
Inherent Right to Self-Government Policy	1995	Information
RCAP*	1996	Information
Health Transition Fund*	1997	Economic Tools
First Nations and Inuit Home and Community Care Program (FNIHCCP)	1999	Economic Tools
Kelowna Accord	2005	Information
United Nations Declaration on the Rights of Indigenous Peoples, Canada*	2010	Information
Evacuation Policy	2011	Regulation

*Indicates policies that are mentioned in the article. All remaining policies are not mentioned, as their background or context extends beyond the scope of this article's focus (e.g., are not directly comparable to the United States, are not related to the reform discussed, etc.). More information on each policy listed in Appendix 2 is available in Webb (2021).

APPENDIX 3. List of US Policies Included in This Review, Date of Introduction, and Use of Policy Instrument

POLICY	YEAR	POLICY INSTRUMENT
Royal Proclamation*	1763	Regulation
Indian Reorganization Act	1934	Regulation
House Concurrent Resolution 108*	1953	Regulation
Transfer Act	1954	Regulation
Community Health Medic Training Program*	1970	Economic Tools
ISDEAA*	1975	Economic Tools
Indian Health Care Improvement Act*	1976	Regulation
Cervical Cancer Mortality Prevention Act	1994	Economic Tools
United Nations Declaration on the Rights of Indigenous Peoples, US*	2007	Information
Reauthorization of IHCIA	2010	Regulation
Affordable Care Act	2010	Economic Tools
Prevention and Public Health Fund*	2010	Economic Tools

*Indicates policies that are mentioned in the article. All remaining policies are not mentioned, as their background or context extends beyond the scope of this article's focus (e.g., are not directly comparable to Canada, are not related to the reform discussed, etc.). More information on each policy listed in Appendix 3 is available in Webb (2021).