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Strengthening Policy for First Nations Self-Determination in Health: An Analysis of Problems, Politics, and Policy Related to Medical Travel in Northwest Territories

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Abstract

Medical travel, where a patient travels to a larger centre for services not available in their home community, is a critical element of the Northwest Territories (NT) health care system. For residents with a valid NT health care card who do not have other coverage for medical travel, the territorial government administers some travel benefits through the NT Medical Travel Program as well as the federally funded non-insured health benefits program. The Gwich'in Tribal Council (GTC) recognizes that medical travel constitutes a major burden and presents extraordinary challenges for Gwich'in living in small remote communities in NT. In 2020, the GTC conducted research that suggests current policy and programs provide only partial access to care. Informed by Gwich'in medical travel stories and drawing from literature on the concepts of health care access, knowledge, power, and Indigenous rights, this article reframes prevailing understandings of the problems, politics, and policy associated with medical travel in NT. The authors contend that relevant and equitable medical travel in NT depends on policy-making that engages First Nations as equal partners with different levels of government and describe key considerations relevant to policymakers in NT and throughout Canada.

Les déplacements pour motifs sanitaires, dans lesquels un patient se déplace vers un centre urbain plus grand pour recevoir des services non disponibles dans sa communauté, sont un élément critique du système de soins des Territoires du Nord Ouest (TNO). Le gouvernement territorial offre des aides aux déplacements pour les résidents munis d'une carte de santé valide des TNO dépourvus d'autre forme de couverture pour déplacements sanitaires, à travers le programme de déplacement sanitaire des TNO ainsi qu'à travers le programme fédéral de services de santé non assurés. Le Conseil Tribal Gwich'in (CTG) a reconnu que les déplacements sanitaires représentaient un fardeau écrasant et des défis extrêmes pour les Gwich'in vivant dans des petites communautés isolées des TNO. En 2020, le CTG a conduit une recherche montrant que les programmes et politiques actuelles ne procure qu'un accès partiel aux soins. Cet article, en se fondant sur des récits de déplacements sanitaires de Gwich'in et en utilisant la littérature sur les concepts d'accès aux soins, la connaissance, le pouvoir et les droits autochtones, propose une autre lecture des problèmes et politiques liées aux déplacements sanitaires dans les TNO. Les auteurs affirment que des déplacements sanitaires de qualité et équitables dans les TNO seront le fait d'un processus de décision engageant les Premières Nations comme partenaires à part entière avec les différents niveaux de gouvernement et ils listent les considérations clés pour les décideurs politiques aux TNO et à travers le pays.

Key Messages

- In Northwest Territories (NT), particularly in small communities where most residents identify as First Nations, Inuvialuit, or Métis, accessing insured health services often involves travel that can last a day or more.
- An expanded understanding of "access"—including accessibility, availability, affordability, adequacy, acceptability, and awareness of services—provides a useful frame for identifying barriers to be addressed in NT medical travel policy.
- Collaboration with Indigenous clients and organizations has potential to transform policy-making processes and produce effective, equitable policy.
- For collaboration to meaningfully respond to community needs, organizations must consider how to disrupt harmful power differentials between non-Indigenous and Indigenous people and their ways of knowing.

Messages-clés

- *Dans les Territoires du Nord-Ouest (TNO), en particulier dans les petites communautés dans lesquelles la plupart des résidents s'identifient comme Premières Nations, Inuvialuit ou Métis, accéder à des services assurés de santé requiert souvent un déplacement d'un jour ou plus.*
- *Une notion élargie « d'accès » —qui inclue l'accessibilité, la disponibilité, l'abordabilité, l'adéquation, l'acceptabilité et la connaissance des services—fournit un cadre utile pour identifier les barrières à surmonter pour une politique de déplacement sanitaire dans les TNO.*
- *La collaboration avec les clients et organisations autochtones permettra de transformer le processus de décision politique et de produire des politiques efficaces et équitables.*
- *Pour que la collaboration réponde de façon réelle aux besoins des communautés, les organisations doivent envisager de remettre en cause les différentiels de pouvoir néfastes entre les peuples autochtones et non autochtones et leurs modes de connaissance.*

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1 INTRODUCTION

Medical travel, where a patient travels to a larger centre for services not available in their home community, is a critical component of health care in Northwest Territories (NT). While health services are concentrated in the city of Yellowknife, which is home to nearly half the territory's residents and a predominantly (76%) non-Indigenous population (NWT Bureau of Statistics 2018), specialty care remains limited. In the other 32 communities in NT, where a majority (89%) of residents self-identify as First Nations, Inuvialuit, or Métis (NWT Bureau of Statistics 2018), accessing all but the most basic insured health services may involve travel to Yellowknife or another regional centre in the territory. Travel outside the territory, typically to Edmonton, Alberta, may be required to access more specialized care.

The support available to medical travellers differs based on their employment, income level, dependents, and eligibility for benefits programs. For residents with a valid health care card who do not have other coverage for medical travel through an employer or worker's compensation insurance, the Government of NT administers travel benefits through the NT Medical Travel Program and the federally funded non-insured health benefits (NIHB) program. These benefits are intended to remove economic barriers to accessing "necessary and appropriate insured health services" (Government of Northwest Territories 2015).

Medical travel nonetheless constitutes a major burden and concern among patients in small NT communities. For example, for those in the Beaufort Delta region—which borders the Yukon to the west, Nunavut to the east, and the Arctic Ocean to the north—considerable time, resources, and logistics are necessary to travel to the regional centre, Inuvik, or thousands of kilometres further afield to Yellowknife or Edmonton. In severe weather conditions, a one-way trip to the doctor may take multiple days.

The Gwich'in Tribal Council (GTC), which is headquartered in Inuvik and represents participants of the Gwich'in Comprehensive Land Claim Agreement, will eventually transition into the Dinjii Zhuh Regional Government when it achieves self-government (for which negotiations with Canada are ongoing). One of its objectives for the Dinjii Zhuh government is to improve the health and quality of life of Gwich'in. At present, the GTC is regularly approached by Gwich'in who need support to either pay expenses not covered by their benefits, advocate for their health care needs, or navigate the medical travel system. Moreover, through the Gwich'in Development Corporation, the council's business arm, the GTC co-owns Larga Ltd., which provides accommodation and ground transportation services to thousands of NT and Nunavut patients receiving health care in Edmonton every year. The GTC thus has a strong interest in research that privileges Gwich'in perspectives of medical travel and informs efforts to achieve equitable access to health care. In this paper, we examine the problems, politics, and policy associated with medical travel in NT and recommend key items to consider for a renewed policy framework.

2 HISTORY AND CONTEXT

A discussion of medical travel and equitable access to health care must be situated in the context of ongoing colonialism.[1] This requires an examination of the fundamental structural determinants of health for First Nations peoples living in Canada, including those that created the health disparities we see today.

In 1867, the *British North America Act* placed all matters related to Status First Nations under federal jurisdiction, and matters related to health and health care under provincial jurisdiction, creating an ambiguity around government responsibility for Indigenous health that persists to this day. The 1876 *Indian Act* contained a health-related provision in Section 73 that stated the federal government "may furnish sufficient aid. . . for the relief of such sick, disabled or destitute persons" but otherwise did not clarify the federal government's role in providing health care (Hinge 1978). Aside from Treaty 6, whose text contains the promise of a "medicine chest," the "numbered treaties" signed between 1871 and 1921[2] also failed to clarify in writing the federal government's responsibility for First Nations health. Yet there is substantial evidence—including Treaty Commissioners' notes—that medicines and health care were requested and promised during negotiations for Treaties 7, 8, 9, 10, and 11 and were therefore understood by First Nations signatories to be included in the treaties' terms (Fumoleau 1973; Waldram, Herring, Young 2006; Lavoie et al. 2012; Lux 2018; Boyer 2019; Craft and Lebihan 2021).

The federal government did not open a nursing station on a First Nations reserve until 1930 (Boyer 2019). Indeed, there was little federal response to First Nations peoples' health until the post-war period of the 1940s and 1950s when concerns were raised about high rates of infant mortality and tuberculosis (Zelmanovits 2003). Although the Indian Health Service (IHS)—which transferred in 1945 from Indian Affairs to the new federal department of National Health and Welfare—established nursing stations in communities throughout the North to provide basic health services such as maternity care (Zelmanovits 2003), its focus remained on substandard "Indian Hospitals" that were the mainstay of a segregated health system for Indigenous peoples (Lux 2018). These hospitals originated in missionary hospitals that had hitherto attempted to fill a stark service gap by providing rudimentary care to Indigenous peoples on reserves and in the North, the costs of which were shared between the respective Christian denominations and federal governments of the day (Lux 2018). By 1945, Canada was pulling back its support to sectarian hospitals, marking a new era of bureaucratic control over First Nations health care (Lux 2018).

Reduced federal support for missionary care was felt acutely in the North, where the

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[1] Given our attention in this paper to the experiences and perspectives of Gwich'in living in NT, we limit this abbreviated history of structural determinants of health as they relate to First Nations living in Canada. This is not meant to deny the similar consequences of colonization experienced by Inuit and Métis peoples.

[2] The last of the numbered treaties, Treaty 11, was signed by northern First Nations including Gwich'in living in present-day Tsiigehtchic and Fort McPherson, NT in 1921.

few hospitals that existed were already poorly equipped and understaffed—a situation compounded by an IHS decision in 1937 to concentrate federal resources on First Nations patients in the provinces who were “in contact with and a menace to white populations” to a greater extent than were Indigenous peoples in the North, where relatively few settler Canadians lived (Lux 2018, 33). Rather than improve the capacity of northern hospitals, the IHS chose to implement large-scale evacuation of northern First Nations and Inuit to hospitals in the provinces to the south (Grygier 1997). Men, women and children were often forcibly removed from their communities without warning, and some never returned home (Geddes 2017; Lux 2018). This absolute authority held by IHS over its patients was enshrined in law when the *Indian Act* was amended in 1953 to include the *Indian Health Regulations*, which made it a crime for Indigenous people to refuse a medical exam or hospital admission, or to leave a hospital before discharge. So began the normalization of medical travel, consistent with a long tradition of forced relocation and the principle of *terra nullius* that justifies the removal of Indigenous peoples from their lands.

The “menace” that the IHS ostensibly sought to control was infectious disease, specifically tuberculosis. Nonetheless, the Indian Hospitals functioned as general hospitals that institutionalized patients on the basis of Indigenous identity, not disease, and even failed to isolate tuberculosis patients from those with other ailments (Lux 2018). The quality of care in these hospitals was undeniably poor and included medical experimentation on patients without their consent (Geddes 2017; Lux 2018). Federally-commissioned reports concluded that health care provided to First Nations by IHS was inadequately funded, inadequately staffed (often with unqualified personnel) and markedly inferior compared with public services offered to non-Indigenous patients (Glassco 1962; Hawthorn 1966; Booz Allen & Hamilton Canada Ltd. 1969; Lux 2018).

One study, completed by consultants hired by National Health and Welfare, recommended a reorganization and renewal of relationships between the federal government, provincial governments, and First Nations communities based on greater community participation in health care planning and delivery (Booz Allen & Hamilton Canada Ltd. 1969). Instead, the 1969 *Statement of the Government of Canada on Indian Policy* (the “White Paper”) sought to do away with the legal relationship between Canada and First Nations and Inuit by abolishing the *Indian Act* (Cairns 2011). Seeing this as an effort to offload responsibility for First Nations health care, First Nations leaders responded with *The Unjust Society* (the “Red Paper”), which called for enhanced community control of health programs (Cardinal 1969).

The first sign of change in federal policy was the 1979 Indian Health Policy, which recognized that a greater degree of Indigenous control of health programs should lead to better health outcomes (Lavoie, Forget, O’Neil 2007). This was followed in 1986 by the Health Transfer Policy, still in place today, instituted to provide a framework to transfer resources for phased control by individual Indigenous communities in the provinces (Waldram, Herring, Young 2006). Yet paradoxically, even today, the federal government retains a level of authority over Indigenous self-determination in health care (Webb et al. 2022) and there are repeated calls for enhanced community control and higher quality services (Dussault and Erasmus 1996; Truth and Reconciliation Commission of Canada 2015; National Inquiry into Missing and Murdered Indigenous Women and Girls 2019) amidst mounting evidence regarding systemic problems in First Nations health care, including persistent systemic racism (Allan and Smylie 2015; Phillips-Beck et al. 2020).

In addition, the coordination of services remains a challenge. Descended from the *British North America Act*, the Canadian constitution places First Nations under federal jurisdiction and health care systems and services under the provinces and territories creating chronic confusion and disagreement between governments about who is responsible for First Nations health care and its costs (Lavoie et al. 2015; Boyer 2019). For this reason, in 2007 the Canadian Parliament passed Jordan's Principle, which dictates that services for First Nations children must be paid for up front by the government of first contact, with jurisdictional disputes resolved later (Boyer 2019). However, Jordan's Principle is not enshrined in law or even policy, and Canada has repeatedly been found by the Canadian Human Rights Tribunal to be non-compliant (Levesque 2018).

The administration of medical travel in NT thus flows from a governance framework that not only depends on tertiary care in southern urban centres, but also creates differential accessibility of health care. This framework was long-established before 1988, when the Government of Canada transferred responsibility for health care to the Government of NT. Despite concerns about the potential impact on land claim and self-government negotiations expressed by the Dene Nation (originally the Indian Brotherhood of the Northwest Territories, a political organization formed in response to the 1969 White Paper), Indigenous organizations supported devolution because they believed new regional boards would afford their people more control over health care (Weller 1990; O'Neil 1995). However, the federal government remained constitutionally responsible for the NIHB program, including medical travel for status First Nations and Inuit, and the territorial government role in the program was limited to its administration (Weller 1990).

Today, the NT communities most reliant on medical travel are the smallest ones, with predominantly First Nations, Inuvialuit, or Métis populations. Recognizing challenges in meeting patient needs, the territorial government launched a project in 2014 to update the NT Medical Travel Program that included consultation and engagement with more than 200 residents living in the capital and six other communities (DPRA 2015). The project resulted in revisions to the NT Medical Travel Policy in 2015 (Government of Northwest Territories 2015), followed in 2019 by the release of a set of Ministerial Policies related to benefits, eligibility, escorts, and appeal processes, which continue to guide the administration of medical travel (Government of Northwest Territories n.d.).

The territorial government also enacted cost-saving measures in 2019 to align with increasing travel costs. Notably, the travel co-payment that patients must reimburse the government was raised from $125 to $200 per one-way flight. In most cases, this co-payment is paid through employer benefits or supplemental health benefits such as NIHB, but anyone without benefits, whose income exceeds a certain threshold, is responsible for these costs of accessing care (Government of Northwest Territories 2019).

Undeniably, medical travel requires significant financial investment by the government. Per capita health expenditures in the territory are more than double the national average and, at nearly $14,000, and are second only to Nunavut (Canadian Institute for Health Information 2021). Medical travel, including emergency medical evacuations, accounts for approximately 5% of the health department's budget (Young et al. 2019). Further, NT is home to nearly 28,000 clients eligible for the federally funded NIHB program, which provides coverage for travel to medically necessary care—including vision care, dental care, and mental health counselling—totalling over $96M in NIHB expenditures across NT, Nunavut, and the Yukon from 2020 to 2021 (Indigenous Services Canada 2022).

3 ANALYSIS OF MEDICAL TRAVEL POLICY IN NORTHWEST TERRITORIES

3.1 Applying Gwich'in knowledge to understand the problem

For patients and their families trying to make sense of a multi-tiered system of services and benefits, the costs of medical travel are not merely financial. More information and support are needed to ease the burden (Kerber et al. 2019). In 2019, the GTC and the lead author of this paper (CM) secured funding from the Canadian Institutes of Health Research and Government of NT for CM, a non-Indigenous PhD candidate from NT, to assume a part-time Health System Impact Fellowship as a researcher embedded within GTC (Canadian Institutes of Health Research 2022). GTC requested research to better understand the challenges faced by Gwich'in medical travel patients and identify ways the GTC could help. CM led a qualitative study starting in summer 2020, by which time she had transitioned to a full-time position as manager of the GTC's health and wellness department. The co-authors (SIF and MD) provided academic support, while ultimate oversight in research design, data collection and interpretation came from Gwich'in Elders, leaders, and colleagues at GTC.

The study drew from practices based on Indigenous storywork, developed by Q'um Q'um Xiiem of Stó:lō First Nation, also known as Jo-ann Archibald, who describes it as both a research method and means of learning through relating to other humans (Archibald 2008). Principles of Indigenous storywork, as well as core Gwich'in values—including respect, honesty, fairness, sharing, caring, spirituality, and stories—upheld the research. The University of Toronto granted ethics approval (protocol #38611) and the Aurora Research Institute granted a research license (#16711) as well as additional financial support to GTC.

In-depth medical travel stories were shared by 10 adult Gwich'in living in the Gwich'in Settlement Area of the Beaufort Delta. Storytellers were asked to share their medical travel story and then given time to tell their story with minimal prompting or questions. Due to the COVID-19 pandemic, all story sessions were conducted by CM over the phone except one, which was shared in writing.

The stories that were shared illustrate the complexity of Gwich'in patients' concerns about medical travel in NT and align with a conceptualization of access to health care as a construct with six dimensions: accessibility, availability, affordability, adequacy, acceptability, and awareness (Saurman 2016). The Gwich'in stories revealed that while the NT Medical Travel Program is deeply appreciated by patients for addressing basic barriers to accessibility—reducing the time and distance between client and service—it does not eliminate the physical burden of travel and only partially addresses the other five dimensions of access. First, certain services such as peer support, medical interpretation, and ground transportation are unavailable or limited. Second, time off work and added expenses like child care comprise a significant burden on travellers—especially those without other insurance who receive a daily medical travel allowance of only $18 a day, making medical travel financially unfeasible. Third, perceived inconsistencies in who does and does not get a non-medical travel escort, combined with poor coordination or communication, lead to gaps in adequately addressing patient needs. Fourth, experiences of racism, culturally unsafe services, and a common feeling that bureaucrats are motivated more by budgets than service are factors that collectively detract from the acceptability of medical travel. Fifth, travellers may not know about helpful services or how to access them, just as many storytellers perceived hospital providers in NT and Alberta to have limited awareness of northern patients' cultures, communities, and health care experiences, a finding supported by other research (Kerber et al. 2019). A selection of brief story excerpts that illustrate these findings is found in Table 1.

Table 1: Excerpts from Gwich'in medical travel stories, by dimension of access to health care

Accessibility	
An accessible service is within reasonable time and distance.	*I know it is very easy. . . for able-bodied bureaucrats living in Yellowknife. . . to take a 1.5-hour trip to Edmonton and think nothing of it. As her caregiver and non-medical escort, I see a 95-year-old woman doing her very best to take on the physical and mental challenge of a 15-hour trip!*
Availability	
An available service has sufficient services and resources to meet needs.	*And there was a couple times when I had to go down there or called in and asked a question in my language, and they could not provide a translator. They told me they had one, but the one that they had had retired, and they had not replaced anyone there.*

Affordability	
An affordable service considers direct costs to service providers and individuals seeking to access the service.	*So, say like they'll tell you you'll be gone for two days and that'll turn into two weeks, you know? And all these times you're at a boarding home and away from home and your children and. . . the worries about the financial burdens of your children and like, you know. . . . They have to be taken care of and that means babysitting or that means food and making sure everything is okay back home and the same time, that you're okay as a patient.*
Adequacy	
An adequate service is coordinated well and accommodates the individual's needs.	*You know, they wouldn't even give him an escort and he was having eye surgery! So, really. . . we paid for a ticket for myself to go down and we saw the doctor afterwards and the doctor was like, "Oh, well, I'll say in here that you're requesting an escort and see if they approve it," or whatever. And it's like you know that normally a patient that has eye surgery gets an escort, so why are you acting like it's such a big deal to give him an escort?*
Acceptability	
An acceptable service responds to perceptions of the service through a social or cultural lens.	*Because lots of people get turned away if they're Indigenous, if they are thought to be drunk or high when really, they're just sick or something. Which makes me think when I initially started feeling pain, did the doctors just think I was a pill popper and I just wanted medicine? It's just really funny because I don't even like taking Tylenol if I don't absolutely have to.*
Awareness	
A service maintains awareness through effective communication with service providers, communities and individuals seeking to access the service. This includes consideration of context.	*It took me a few years with Mom to fight for an extra day. Because every time she went out for medical—was down for an appointment and be home the next day—it would take her about two weeks to recover. So I saw that for a while and finally they said, "You know, nurses can authorize [an overnight stop in Yellowknife]." And instead of telling me that right at the beginning, they decide to tell me afterwards. After a couple of years.*

Table Note: The first five dimensions of access were identified by Pechansky and Thomas (1981). Saurman (2016) identified awareness as a sixth dimension of access.

The study results were immediately integrated into GTC projects, programs and advocacy. They also serve to deepen understanding of not only the journeys of Gwich'in medical travellers but also a core problem: the medical travel policy framework in NT provides only partial access to care.

3.2 The multiple streams dilemma: aligning problem, politics, and policy for First Nations health care

On its own, the identification of a problem will not necessarily lead to policy reform. According to Kingdon's (2011) multiple streams framework, policy development depends on the issue first being interpreted as requiring government action. Kingdon (2011) suggests that three factors can raise the profile of a problem: indicators, events, and feedback.

In NT, medical travel indicators are scarce. Apart from financial expenditures, publicly available data are limited to the number of travel events and approved escorts per year: 13,579 and 4,840, respectively, in 2020-21 (Northwest Territories Health and Social Services Authority 2021). While these data are valuable, they do not provide sufficient insight into the extent to which the NT Medical Travel Program facilitates access to care by different groups. The Gwich'in medical travel stories suggest that a combination of indicators to reflect all dimensions of health care access would be required. Moreover, equity metrics would require measuring perceived needs among communities or clients in order to construct an understanding of the proportion of clients in need who do or do not receive a service. For example, it may be insightful to document and analyze the number of travel or escort requests that are denied in each region of the territory.

Until a more compelling and comprehensive set of medical travel data becomes available, current events may be more effective at focusing the attention of policymakers. Certainly, the COVID-19 pandemic has highlighted the hardships of medical travel, aggravated by losses of employment income and public health measures such as self-isolation and social distancing that separate patients from their support networks. There was also the temporary suspension of labour and delivery services in Yellowknife during the winter of 2021-2022 due to staffing issues in the hospital obstetrics unit, which unexpectedly forced many birthing individuals to travel to Edmonton or elsewhere to give birth, splitting up families who could not afford the costs of travelling together (Sibley 2022). Covered extensively in the media, this event shone light on the constraints of a medical travel policy centred around individual eligibility criteria rather than supporting the whole family.

Client feedback on medical travel is plentiful and consistent throughout NT. Complaints about medical travel are frequently discussed in the media (Cooper et al. 2021) and Legislative Assembly (for example, see Weyallon-Armstrong 2022), as well as brought directly to Indigenous and territorial government. It is unclear whether feedback is systematically documented in these instances, though GNWT has produced reports that summarize medical travellers' concerns (DPRA 2015). The medical travel stories captured in GTC's research reinforce feedback that has been shared before. For example, the Gwich'in storytellers were concerned about the inequitable distribution of benefits in NT. While individuals without additional coverage—generally, those most in need—are reimbursed only $18 per day, territorial government employees receive generous benefits including a daily meals and incidentals allowance of $138. Another point of contention they raised relates to the interpretation and application of policy on non-medical escorts. Office clerks are empowered to deny physician-backed requests for non-medical travel escorts without meaningful familiarity with the patient's situation, putting the onus on the ill patient or their family to substantiate their need. When Gwich'in approach the GTC for support with medical travel, it is frequently because an escort was denied to a patient experiencing significant challenges such as limited mobility, language barriers, or having to travel for surgeries under sedation or cancer treatment, while other patients with seemingly fewer challenges are approved for escorts. The GTC has pressed both territorial and federal government for changes to address these concerns (Kyikavichik 2022). Some First Nations patients may be successful applying for coverage through stopgap funding under Jordan's Principle (provided they meet specific criteria), but there is otherwise little recourse within a system that privileges rules over patient needs. These situations contribute to a sentiment that the system lacks consistency in decision making, care, compassion, and a sense of community, not to mention that it is confusing and difficult to navigate.

Of course, this is a matter of perspective. Human interpretations of problems are socially and politically constructed, shaped through interactions and experiences (Baker et al. 2018). This may explain why top-down policy in Canada—for example, the reserve system or separating children from their families for schooling—has been so devastating: historically, policy has been built on politics that fail to grasp the reality of problems First Nations peoples face. At the same time, government practices tend to inhibit bringing different ways of knowing into policy-making (Smith 2013; Came 2014). Institutionalized biomedical paradigms, which view health and health care in terms of individual-level behaviours and physical accessibility of services, leave little room in policy for First Nations knowledges or the consideration of structural and cultural contexts (Came 2014; Baker et al. 2018; Horrill et al. 2018). It follows that First Nations communities must have a hand in defining not only policy problems but also policy solutions that affect them.

Indeed, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) states that Indigenous peoples have the right to participate in decisions that affect them; Article 23 specifies that this right includes active involvement in the development and administration of health programs (UN General Assembly 2007). The Government of Canada affirmed these rights in 2021 by passing the *UNDRIP Act*. The Government of NT has also committed to implementing UNDRIP, which would include incorporating UNDRIP into territorial legislation (Brackenbury 2020). For its part, the GTC has stated its willingness to assume responsibility for administering the medical travel program for Gwich'in

(Kyikavichik 2022).

Careful scrutiny and decolonization of power structures and processes are required for meaningful involvement of First Nations peoples in policy (Fridkin, Browne, Stout 2019), including acknowledging that racism exists in policy-making processes (Came 2014). This does not mean that individuals working within these systems are not good people. Racism is a system of institutionalized prejudice and power; without ongoing education and self-reflexivity, it is usually invisible to those with privilege in the system (Phillips-Beck et al. 2020; Elias and Paradies 2021). Bringing diverse groups together to share stories and explore their meaning can give way to new understandings of policy and policy-making as reflexive and empowering processes designed to dismantle harmful structural determinants of health (Van Hulst and Yanow 2016).

4 POLICY CONSIDERATIONS IN SUPPORT OF INDIGENOUS SELF-DETERMINATION IN HEALTH

Self-determination refers to control over one's own choices and affairs. Meaningful participation and decision-making by First Nations in the structures and processes that govern them is, by definition, an important element of self-determination. This is as true for health and health care as it is for other areas such as lands or economic development and reflects the crux of a need for system reform. From a rights perspective, this is underscored by UNDRIP, which asserts that Indigenous peoples have a right to self-determination as well as health of the highest standard (UN General Assembly 2007).

Stemming from this analysis of medical travel policy in NT, the following points constitute recommendations to federal and NT government policymakers. At the same time, they represent important ideas and principles that are relevant throughout Canada and should be considered by governments and organizations in all jurisdictions as they enact their responsibility to support First Nations, Inuit, and Métis self-determination in health.

- **Establish processes for renewed dialogue and co-design of a comprehensive medical travel policy framework for NT, supported by NIHB**: In partnership with Indigenous governments and community members, begin by nurturing relationships and a shared sense of the policy problem. Then work collaboratively to define the aims and processes of policy-making, taking all 46 articles of UNDRIP into account. Create a safe space for sharing story and values from western and Indigenous ways of knowing so that problems and proposed solutions are examined from multiple perspectives. Remain open to structural changes such as tripartite arrangements that augment the role of Indigenous organizations.
- **Evaluate the medical travel program, including how Indigenous, territorial, and federal governments work together**: This evaluation should assess the effectiveness and efficiency of medical travel with respect not only to costs and health outcomes but also the needs and values of NT residents. Conducting a patient journey

mapping exercise would help to capture the varied experiences of patients and families interacting with complex systems and processes (McCarthy et al. 2016; Kelly et al. 2017). Further, this evaluation should be guided by principles and practices of Indigenous evaluation including relationship, cultural safety, and Kirkness and Barnhardt's (2001) "four Rs" of respect, relevance, reciprocity, and responsibility.

- **Adopt an expanded understanding of access to health care**: Access is a multi-dimensional concept with at least six dimensions: accessibility, availability, affordability, adequacy, acceptability, and awareness (Saurman 2016). Consider barriers to access and the extent to which different groups require additional support from within the system to gain access to services. As per UNDRIP Article 22.1, also consider the rights and special needs of Indigenous elders, women, youth, children, and persons with disabilities (UN General Assembly 2007).
- **Adopt an equity mindset in policy and decision-making**: Establish a common standard for all NT residents, then determine what different groups will need to be able to reach that standard. This will require data gathering and analysis as well as redirecting resources to where they will have the greatest impact—likely toward reducing barriers to access among those with the greatest unmet need. Additionally, institutionalize a feedback mechanism to ensure continual learning and policy responsiveness.
- **Identify and interrupt persistent systemic power imbalances**: Power differentials between non-Indigenous and Indigenous people, organizations, and worldviews impede cultural safety and perpetuate racism. Policy processes and relationships that promote trust, reciprocity, and shared decision-making will be more successful at learning from diverse knowledges and responding to community needs. Education and self-reflexivity must be embedded into organizational practices. A starting point would be cultural safety and anti-racism training for public servants, including medical travel managers and clerks. The Government of NT has taken crucial first steps with its Indigenous Cultural Awareness and Sensitivity Training and the cultural safety action plan launched in 2018 by the Department of Health and Social Services.

5 CONCLUSION

The current medical travel policy framework in NT does not sufficiently bridge barriers to accessing care and may therefore contribute to reinforcing health inequities. Renewed dialogue and partnership between settler and Indigenous governments are necessary to reform a system vital to NT communities and to demonstrate respect for Indigenous strengths, knowledges, and values. For Gwich'in and other First Nations, Inuit, and Métis peoples, support through policy and policy-making to reclaim what was taken by colonization is an essential act of reconciliation.

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