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Exploring Shifts in Indigenous Primary Health Care Policy Development in Alberta, Canada

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Abstract

Primary health care (PHC) transformation continues to be identified as a key pathway to achieve health equity for Indigenous peoples. In Alberta, varying degrees of PHC services exist within First Nations, Métis, and urban contexts that are fragmented, under-resourced, and disconnected from each other, perpetuating existing health inequities. A retrospective policy analysis was conducted to a) analyze federal, provincial, and local policies to advance Indigenous PHC in Alberta; and b) examine the engagement of Indigenous peoples in PHC policy and decision-making. The review found that prior to and into the early 1960s, the federal government controlled Indigenous peoples' rights to health. By the end of the decade, the federal government shifted their responsibilities to Indigenous peoples in an attempt to reduce their role in health care delivery. In the late 1970s, the federal government reaffirmed their responsibilities in providing PHC to Indigenous peoples by establishing Indigenous-specific policies. This led to the creation of many co-designed reforms and initiatives provincially to increase Indigenous participation in policy throughout the 2000s. Despite these advancements, more work is needed to ensure that health priorities important to Indigenous peoples are appropriately addressed. Future Indigenous PHC-focused policy reforms can enhance Indigenous health experiences by clarifying the roles of federal, provincial, and Indigenous governments in the coordination of PHC; by ensuring Indigenous representation at all relevant decision-making tables; and by actively working to decolonize the health care institution and promote health equity.

La transformation des soins de santé primaires (SSP) continue d'être identifiée comme une voie clé pour atteindre l'équité en matière de santé pour les peuples autochtones. En Alberta, il existe divers degrés de SSP au sein des premières nations, des métis et des contextes urbains qui sont fragmentés, manquent de ressources et sont déconnectés les uns des autres, ce qui perpétue les iniquités dans la domaine de la santé. Une analyse rétrospective des politiques a été menée pour a) analyser les politiques fédérales, provinciales et locales visant à faire progresser les soins de santé primaires autochtones en Alberta et b) examiner l'engagement des peuples autochtones dans la politique et la prise de décision en ce qui concerne les SSP. Les résultats de l'analyse ont montré que, jusqu'au début des années 1960, le gouvernement fédéral gérait les droits des peuples autochtones en ce qui concerne la santé. À la fin de la décennie, le gouvernement fédéral a transféré ses responsabilités aux peuples autochtones dans le but de réduire son rôle dans la prestation des soins de santé. À la fin des années 1970, le gouvernement fédéral a réaffirmé ses responsabilités en fournissant des soins de santé primaires aux peuples autochtones, en établissant des politiques spécifiques aux peuples autochtones. Cela a mené à la création de nombreuses réformes et initiatives coconçues au niveau provincial afin d'accroître la participation des autochtones à la politique tout au long des années 2000. Malgré tous ces progrès, il reste encore du travail à faire pour

s'assurer que les priorités de santé importantes pour les peuples autochtones sont prises en compte de manière appropriée. Les futures réformes politiques axées sur les soins de santé primaires autochtones peuvent améliorer les expériences de santé des autochtones en clarifiant les rôles des gouvernements fédéral, provinciaux et autochtones dans la coordination des SSP, en garantissant la représentation des peuples autochtones à toutes les instances de décision pertinentes et en œuvrant activement à la décolonisation de l'institution des SSP pour promouvoir l'équité dans la santé.

Positionality: Danika Goveas is a second-generation settler from Algonquin Territory (Ottawa) and currently resides on Treaty 8/Métis Nation of Alberta Region 4 (Edmonton). She has been engaged in collaborative research projects focused on Indigenous health for six years and is grateful to continue learning about Indigenous ways of knowing throughout her MSc thesis. Danika is a trainee with the Collaborative Applied Research for Equity in Health Policy and Systems (CARE) Research Lab and the Indigenous Primary Health Care and Policy Research Network (IPHCPR), both of which continue to support her research and provide ongoing training and mentorship.

Positionnalité: Danika Goveas est un colon de deuxième génération originaire du territoire algonquin (Ottawa) et réside actuellement sur le Traité 8/region 4 de la Nation métisse de l'Alberta (Edmonton). Elle participe depuis six ans à des projets de recherche collaborative axés sur la santé autochtone et est reconnaissante de continuer à apprendre sur les modes de connaissance autochtones tout au long de sa thèse de maîtrise. Danika est une stagiaire du laboratoire de recherche CARE (Collaborative Applied Research for Equity in Health Policy and Systems) *et du réseau IPHCPR* (Indigenous Primary Health Care and Policy Research Network), *qui continuent à soutenir ses recherches et à lui offrir une formation et le mentorat.*

Key Messages

- Jurisdictional disputes between federal and provincial governments over health care responsibilities have created a patchwork of Indigenous policies and programs.
- Collaborative structures and governance models can enhance Indigenous engagement in policy and decision-making.
- Indigenous peoples need to be represented at decision-making tables to ensure the creation of sustainable PHC policies and programs.
- Having distinctions-based approaches that recognize the specific rights, interests, and concerns of each group is integral to achieving health equity for all Indigenous peoples.

Messages-clés

- *Les conflits de juridiction entre les gouvernements fédéral et provinciaux sur les responsabilités des soins de santé ont créé un ensemble disparate de politiques et de programmes autochtones.*
- *Les structures de collaboration et les modèles de gouvernance peuvent renforcer l'engagement des peuples autochtones dans la politique et la prise des décisions.*
- *Les peuples autochtones doivent être représentés aux tables de décision afin d'assurer la création de politiques et de programmes de SSP fiables.*
- *L'adoption d'approches fondées sur les distinctions, qui reconnaissent les droits, les intérêts et les soucis spécifiques de chaque groupe fait partie intégrante de la réalisation de l'équité en matière de santé pour tous les peuples autochtones.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Research evidence demonstrates that Indigenous peoples in Canada face continued systemic and complex barriers in accessing primary health care (PHC) services (Henderson et al. 2018; Montesanti et al. 2018). Varying degrees of PHC services exist within First Nations, Inuit, Métis, and urban contexts, which remain chronically underfunded and disconnected from other mainstream PHC services (Crowshoe, Montesanti, and Barnabe 2022). Furthermore, jurisdictional boundaries cause fragmentation and siloing of resources, resulting in complexities for Indigenous health care service delivery in Canada. Six years after the release of the 94 Calls to Action by the Truth and Reconciliation Commission of Canada (TRC), there is increasing pressure on governments to close gaps on health inequities for Indigenous peoples. Addressing the historical influences that undermine Indigenous peoples health and access to PHC is key to driving PHC system transformations to advance Indigenous health equity (Crowshoe et al. 2019). This retrospective policy analysis examines how historical policies have shaped Indigenous PHC policy development over nearly six decades in Alberta.

2 HISTORY AND CONTEXT

2.1 Responsibilities for Indigenous health

Jurisdictional responsibilities for Indigenous peoples' health care are divided across federal, provincial, and territorial governments. Indigenous Services Canada (ISC) provides funding and health care services for on-reserve First Nations (ISC 2021). Additionally, ISC funds non-insured health care benefits (NIHB) to eligible First Nations and recognized Inuit (ISC 2021). ISC does not have a mandate to provide health services for Métis and non-status First Nations; therefore, services and benefits fall under provincial/territorial (P/T) responsibility (ISC 2021).

Under the 1984 *Canada Health Act* (CHA), P/T governments are responsible for the delivery of universally accessible health care for all citizens (Health Canada 2020). However, coverage of Status and/or Treaty Indians is not outlined in the CHA. Under the CHA, provinces have agreed to deliver insured health services to all persons residing in the province, which includes Indigenous residents, regardless of whether they live on or off reserve. Responsibilities for Indigenous health policies and programming fall across several jurisdictions, resulting in poorly coordinated service delivery and complexities for Indigenous PHC system users (Lavoie 2013; ISC 2021).

2.2 The legacy of historical Indigenous health experiences: emergence of tuberculosis and establishment of Indian hospitals

Indigenous peoples have been impacted by forces of colonization and ongoing structural violence. In the late 1870s, Indigenous peoples in Alberta suffered from widespread famine, largely due to the collapse of buffalo herds (Daschuk 2019). Poor response from the federal government to supply food rations caused the rapid emergence of tuberculosis (TB) in the early 1880s. Undernourishment is a known determinant of TB, and as such, the limited availability of food resulted in deaths across many reserve populations (Daschuk 2019). Indigenous peoples began protesting the federal government's negligence to protect them from famine and disease, which were responsibilities entrusted under the Medicine Chest Clause of 1876 (Daschuk, 2013). This clause was secured under Treaty 6 and created to guarantee health care services for Indians, in cases of natural disasters or disease outbreaks (Daschuk 2013). This clause was also said to have been verbally contained in oral versions of other treaties (Craft and Lebihan 2021).

Under the guise of containing the spread of TB, Indian hospitals were created in the 1930s (Daschuk 2019).[1] The Indian Residential School History and Dialogue Centre at the University of British Columbia highlights that Indian hospitals were established to create segregation and to control the perceived threat that Indigenous peoples imposed on non-Indigenous people (University of British Columbia 2021). Patients would commonly experience enforced hospitalization and physical restraint (University of British Columbia 2021). Beyond Indigenous peoples' experience with Indian hospitals, there are several other instances of medical abuse towards Indigenous peoples that remain undocumented, and Indigenous peoples continue to experience racism and discrimination from the health care system.

3 UNCOVERING THE STORY OF INDIGENOUS PHC POLICY IN ALBERTA

3.1 Methods

This policy analysis was guided by historical institutionalism and punctuated equilibrium theory to explain shifts in Indigenous PHC policy development within Alberta. Historical institutionalism highlights the significant role of institutions in shaping policy decisions and outcomes, as political struggles are often mediated by the contexts within which they take place (i.e., by government) (Steinmo et al. 1992). Punctuated equilibrium theory highlights how factors influencing the policy subsystem (e.g., policy communities or coalitions) can

[1] Many terms have been used to describe the first peoples of Canada. Today, the term *Indigenous* is used as an encompassing term for First Nations on- and off-reserve, Inuit, Métis, and non-status individuals of First Nations ancestry. *Indigneous* is used in this paper when statements or documents apply to all groups. In this article, the terms "Indian" and "Aboriginal" are used when referencing historical documents.

create periods of extreme policy stability and those of rapid policy change (True, Jones, and Baumgartner 2007).

Incremental historical policy developments within Indigenous PHC are not well documented. Consequently, we convened a virtual meeting in February 2022 with key policy actors in Alberta to develop a timeline of policy events related to the shifting policy contexts shaping Indigenous PHC, historical relationships between the federal government and Indigenous peoples, and how these policy contexts presently influence Indigenous PHC in the province. A systematic policy document search was conducted in accordance with the policy events identified during the virtual meeting. While our policy analysis is focused on Indigenous PHC policy development in Alberta, several federal policy initiatives that have shaped provincial policy decisions are included in this timeline.

Our retrospective policy analysis was aimed at generating insights about how Indigenous health-focused policies were developed and identifying factors that influence policy-making. A document-based, in-depth analysis was conducted for 32 federal, provincial, and local (Alberta) policy documents from 1962-2020, including formal policies, legislation, policy or program evaluations, statements, memorandums of understanding, briefing notes, recommendations, and strategies. Some key documents were digitally inaccessible and were retrieved in hard-copy format through an expert scholar at the University of Manitoba. A table summarizing the key policy documents reviewed is shown in Appendix 1.

Key information was extracted from the policy documents using the Policy Triangle Framework and the Ripples Framework for Meaningful Involvement. The Policy Triangle assesses four key factors involved in policy development and implementation: actors (individuals, groups, and organizations), processes (policy formulation and implementation), context (social, cultural, political, and economic), and content (i.e., policy objectives and guidelines) (Walt and Gilson 1994). While the Policy Triangle Framework provides an assessment of which actors (including Indigenous peoples) were involved in the policy and decision-making process, the Ripples Framework for Meaningful Involvement enabled a deeper exploration of how Indigenous peoples were engaged in PHC policy and decision-making (Fridkin, Browne, and Dion Stout 2019). Detailed results of the analysis are described below.

3.2 Framing health care for Indigenous peoples

3.2.1 Framing government responsibilities on health care delivery for Indigenous peoples

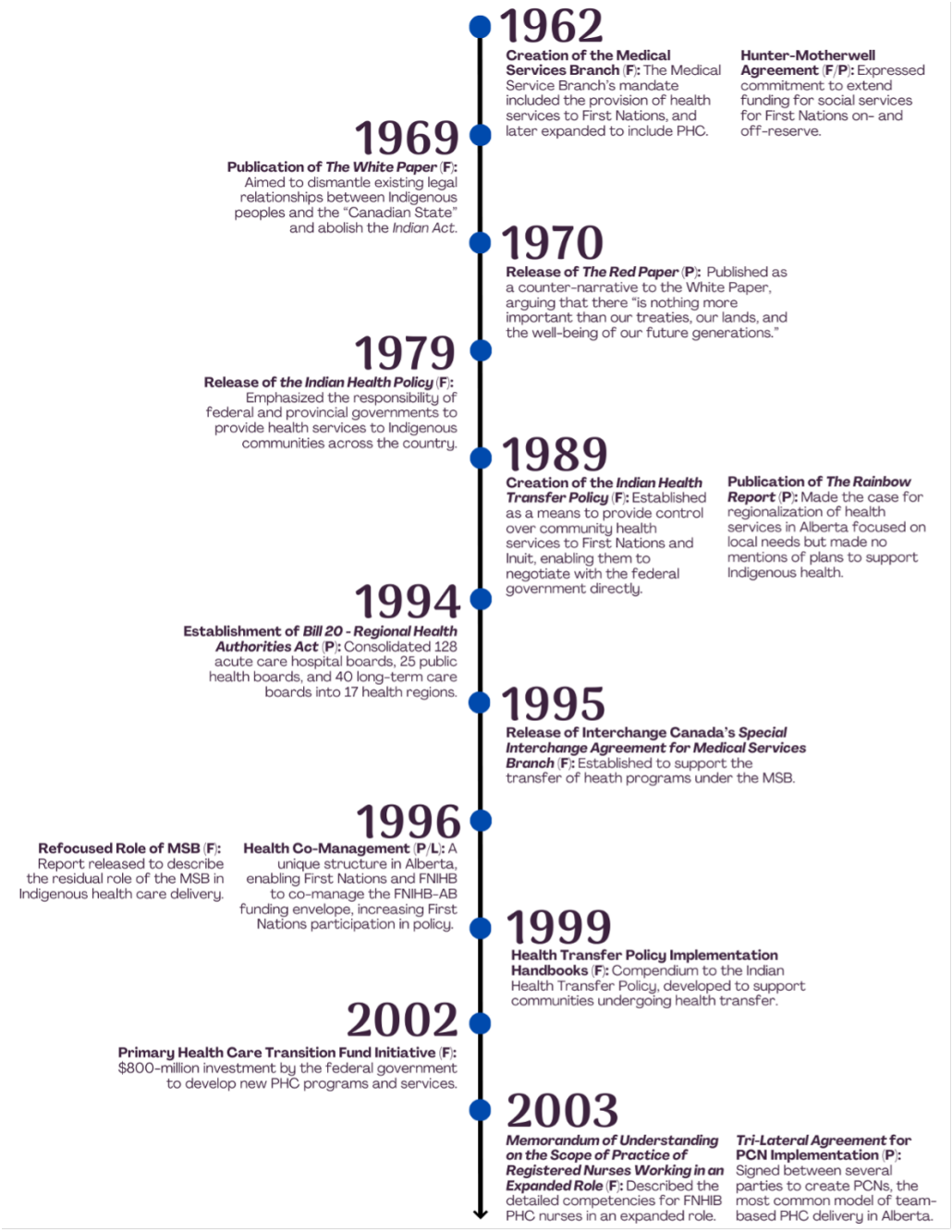
Health care delivery for Indigenous peoples has historically been framed around the federal government's role in the administration of health care services to First Nations and Inuit communities. As previously described, communicable disease, in particular TB, within Indigenous populations was a catalyst for health service development. As the TB crisis was brought under control in the 1950s, it became apparent that there was an urgent

need for health services in Indigenous communities. In 1962, the Medical Services Branch (MSB) was created (later renamed the First Nations and Inuit Health Branch (FNIHB)), mandated to provide health care services to First Nations, which fell outside of provincial jurisdiction. Initially centred on public health priorities, services expanded to include PHC, dental care, NIHB, and more (MSB 1988). The MSB's creation was a defining moment that sparked the federal government's early involvement in health care for First Nations and Inuit communities.

Meanwhile in 1962, the *Hunter Motherwell Agreement* was signed between the federal government and the Government of Alberta (Rogers 1968). The agreement outlined a commitment to extend funding for social services to First Nations on- and off-reserves, stipulating that Indians living off-reserve and not employable would be the responsibility of the federal government, whereas for employable individuals, the province would assume responsibility (Rogers 1968).

Following the signing of the agreement, the province unilaterally deviated away from their stated commitments by applying further restrictions to the categories of off-reserve Indians who would be eligible for assistance (Rogers 1968). The National Social Assistance Review document stated that: "The province administers and funds social assistance to off-reserve Indians who are endeavouring to establish themselves as self-supporting and are members of Alberta Bands" (Government of Canada 1979, 2). As such, the agreement was altered to insinuate that Indians living off reserves must be members of an Alberta Band. The Hunter-Motherwell Agreement demonstrates the first example of governments altering terms of a policy decision to limit the monetary amount of health care support available to Indigenous peoples.

However, the 1969 publication of the *Statement of the Government of Canada on Indian Policy* (called *The White Paper*) was an indication of the government's intention to get out of the business of Indigenous health care altogether. This paper highlighted the government's plan to eliminate Indian status and recognize Indigenous peoples as citizens with the same rights, opportunities, and responsibilities as non-Indigenous people (Government of Canada 1969). The propositions in this paper (if enacted) would have eliminated Indigenous-specific policy initiatives entirely.


1962
Creation of the Medical Services Branch (F): The Medical Service Branch's mandate included the provision of health services to First Nations, and later expanded to include PHC.
Hunter-Motherwell Agreement (F/P): Expressed commitment to extend funding for social services for First Nations on- and off-reserve.
1969
Publication of The White Paper (F): Aimed to dismantle existing legal relationships between Indigenous peoples and the "Canadian State" and abolish the Indian Act.
1970
Release of The Red Paper (P): Published as a counter-narrative to the White Paper, arguing that there "is nothing more important than our treaties, our lands, and the well-being of our future generations."
1979
Release of the Indian Health Policy (F): Emphasized the responsibility of federal and provincial governments to provide health services to Indigenous communities across the country.
1989
Creation of the Indian Health Transfer Policy (F): Established as a means to provide control over community health services to First Nations and Inuit, enabling them to negotiate with the federal government directly.
Publication of The Rainbow Report (P): Made the case for regionalization of health services in Alberta focused on local needs but made no mentions of plans to support Indigenous health.
1994
Establishment of Bill 20 - Regional Health Authorities Act (P): Consolidated 128 acute care hospital boards, 25 public health boards, and 40 long-term care boards into 17 health regions.
1995
Release of Interchange Canada's Special Interchange Agreement for Medical Services Branch (F): Established to support the transfer of heath programs under the MSB.
1996
Refocused Role of MSB (F): Report released to describe the residual role of the MSB in Indigenous health care delivery.
Health Co-Management (P/L): A unique structure in Alberta, enabling First Nations and FNIHB to co-manage the FNIHB-AB funding envelope, increasing First Nations participation in policy.
1999
Health Transfer Policy Implementation Handbooks (F): Compendium to the Indian Health Transfer Policy, developed to support communities undergoing health transfer.
2002
Primary Health Care Transition Fund Initiative (F): $800-million investment by the federal government to develop new PHC programs and services.
2003
Memorandum of Understanding on the Scope of Practice of Registered Nurses Working in an Expanded Role (F): Described the detailed competencies for FNHIB PHC nurses in an expanded role.
Tri-Lateral Agreement for PCN Implementation (P): Signed between several parties to create PCNs, the most common model of team-based PHC delivery in Alberta.

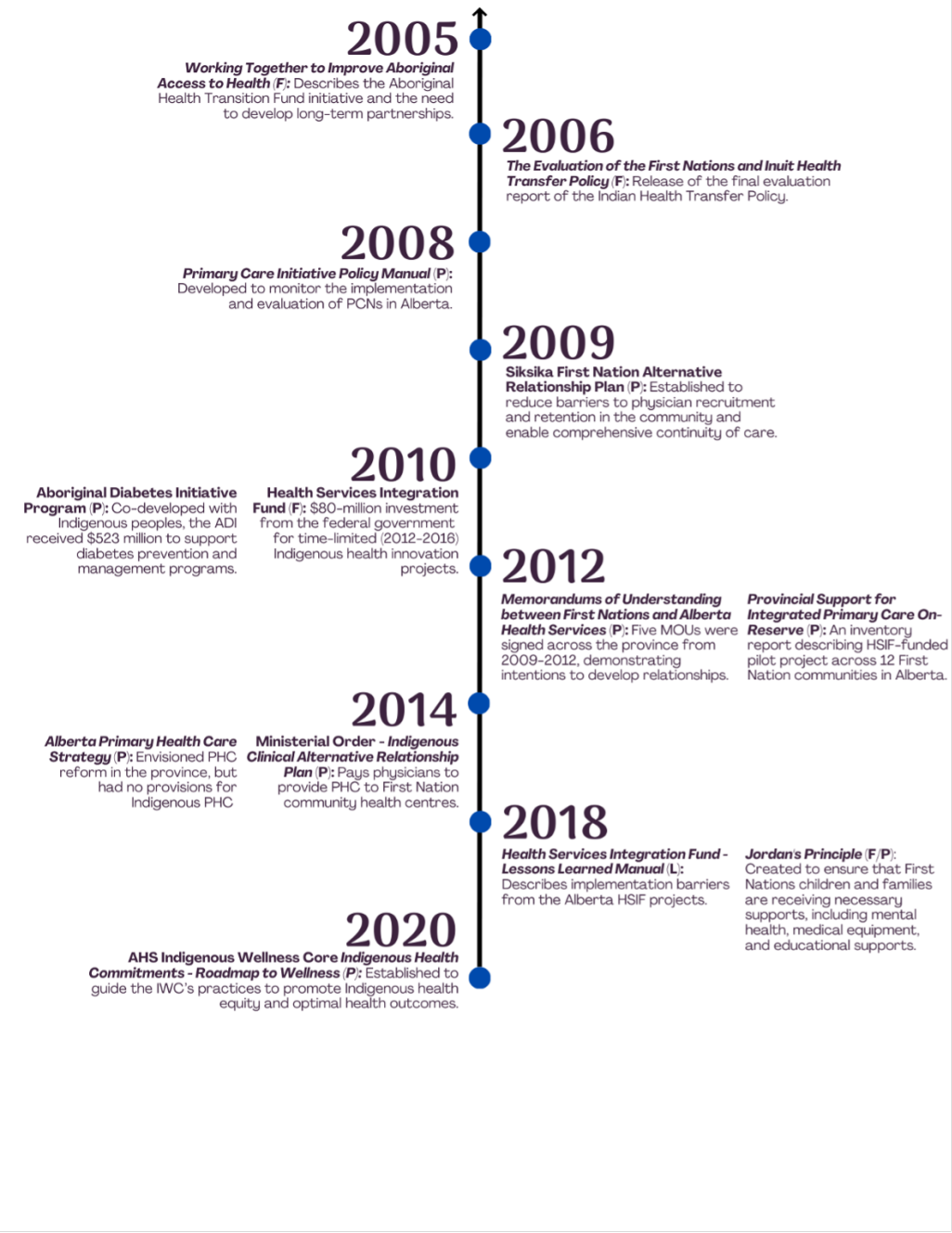


Figure 1: The evolution of Indigenous PHC in Canada and Alberta. (F) indicates federal policy, (P) indicates provincial (Alberta) policy, and (L) indicates local policy in Alberta.

The White Paper was met with intense opposition from Indigenous leaders across the country, igniting a new wave of Indigenous advocacy (University of British Columbia 2009). In 1970, in response to *The White Paper*, Indigenous leaders developed *Citizens Plus* (commonly known as *The Red Paper*), a counter-narrative emphasizing the unique rights and identities of Indigenous peoples and the need for reform (Indian Chiefs of Alberta 1970). Widespread criticism following the publication of *The Red Paper* ultimately caused the retraction of *The White Paper* (University of British Columbia 2009).

3.2.2 Transfer of health services and the residual role of the MSB

Despite Indigenous peoples voicing their concerns over the federal government's responsibilities, the government attempted to reduce their role in health care service delivery to only serve First Nations in 1978. This was met with opposition from the National Indian Brotherhood (now the Assembly of First Nations), a reaction that sparked the release of the 1979 *Indian Health Policy* (IHP) (Lavoie 2018). The two-page statement reaffirmed the need for federal and provincial governments to provide health services for First Nations and Inuit (excluding Métis) (Health Canada 2007a). Furthermore, it committed to improving First Nations and Inuit health by focusing on pillars like community development and relationships between community and the federal government (Health Canada 2007a).

To support the intended goals of the IHP, the Indian Health Transfer Policy (IHTP), titled the *Memorandum of Understanding between the Minister of National Health and Welfare and the Treasury Board Concerning the Transfer of Health Services to Indian Control*, was rolled out by FNIHB in 1989. The IHTP aimed to give control back to Indian people by promoting community responsibility over health services (Treasury Board of Canada 1989). Only First Nations and Inuit situated south of the 60th parallel were eligible to undergo health transfer, once again excluding Métis and northern Indigenous populations (Treasury Board of Canada 1989).

A *Special Interchange Agreement for Medical Services Branch* was established to support the transfer of health programs under the MSB (Interchange Canada 1995). Under the arrangement, dental therapists and community nurses working in an expanded role could be hired directly by First Nations in Alberta and employed under integrated or transfer funding agreements between the federal government and a First Nations community (Interchange Canada 1995). This agreement expanded First Nations access to broader PHC services and afforded First Nations a subtle increase in community control by enabling direct hire of health professionals.

In 1999, Health Canada released three compendium handbooks to the IHTP, highlighting three levels of community control: (1) transfer, (2) integrated, and (3) non-transferred/non-integrated (NTNI) (Health Canada 1999). *Transfer* allows for communities to take over the administration of community-based and regional programs under a single agreement, whereas communities under an *integrated* approach gain less control as they share responsibility for service delivery with FNIHB (Health Canada 1999). NTNI have

no dedicated resources for administration within their agreements (Health Canada 2006).[2] Described as a "success story" by policy actors was the transfer of the NIHB program to Bigstone Cree First Nation, a semi-isolated community in northern Alberta (IPHCPR 2022).[3] In 1996, Bigstone Cree Nation chose to take transferred responsibility of medical transportations and later, took responsibility of all NIHB goods and services (IPHCPR 2022).

Despite commitments to the implementation of health transfer agreements, MSB made continued attempts to limit its role in health care in the 1990s (MSB 1996). In 1996, the Sub-Committee on the Transfer of Health Services to Indian Control released the *Refocused Role of Medical Services Branch* report, defining the residual role of the Branch that was released to all First Nations communities, and extensive discussions were held across the country. Residual roles were required for accountability (e.g., financial, management, and administrative expertise) and professional expertise (e.g., personnel assistance and advice) (MSB 1996). Findings from a long-term evaluation of health transfer noted that despite many communities wanting self-government over health, they did not see the MSB removing itself from their fiduciary responsibilities (MSB 1996).

3.3 Framing of Indigenous peoples' rights to health: Indigenous participation in health care decision-making

As the IHTP was being implemented federally, discussions on health care reform were underway in Alberta. *The Rainbow Report: Our Vision for Health* (1990) was published by the Premier's Commission on Future Health Care for Albertans. The report made the case for regionalization of health services in Alberta focused on local needs, greater attention to human resources planning, increased community participation, and better health data collection, but made no mentions of plans to support Indigenous health (National Library of Canada 1989). The report's recommendations were later used as the foundation for uniting 128 acute care hospital boards, 25 public health boards, and 40 long-term care boards into 17 health regions under the 1994 *Regional Health Authorities Act*.[4]

In response to increased demands for First Nations participation in health policy decision-making, Alberta's Health Co-Management (HCoM) committee was established in 1996. HCoM is a structure unique to Alberta, allowing for First Nations and FNIHB to co-manage the FNIHB-AB funding envelope and reallocate funding efficiencies towards health programs in Treaty 6, 7, and 8 (HCoM 1996). Most importantly, the agreement commits

[2]FNIHB funding of on-reserve health services was based on community size, level of remoteness, and access to provincial services. In Alberta, the level of PHC services available to on-reserve communities include nursing stations in more isolated or remote communities, and health centres in semi- and non-isolated communities.

[3]We were unable to retrieve or locate any policy documents describing the NIHB transfer, but it was described by the policy actors. Publicly available presentations by the Bigstone Health Commission are available online.

[4]The nine standing health authorities were later centralized under Alberta Health Services in 2008.

to increase participation of First Nations in assessing, analysing, planning, and managing programs and services offered by FNIHB Alberta.

3.4 Enhancing collaborations for Indigenous PHC

Limited contributions to PHC transformation were met with sudden attention in the early 2000s, when the federal government invested $800 million towards the Primary Health Care Transition Fund (PHCTF) to develop new PHC programs and services (Health Canada 2007b). Alberta was granted nearly $55 million, which was used to develop Health Link Alberta (a health advisory service) and the Capacity Building Fund (to implement primary care models) between 2002-2006 (Health Canada 2005). A separate funding envelope was also designated towards Aboriginal PHC initiatives, which funded one project in Alberta with the Bigstone Cree Nation to address three main issues related to: (1) integration of health services and collaboration; (2) information-sharing among jurisdictions; and (3) development of a financial reimbursement model for physicians through an Alternate Relationship Plan (ARP) (Health Canada 2007b).

While these federal investments supported PHC transformation projects in some First Nation communities in Alberta, the province was also undergoing wide-scale PHC system reforms in the early 2000s, with a limited focus on Indigenous-specific reforms. Drawing inspiration from the PHCTF, Alberta saw the creation of Primary Care Networks (PCNs) in 2003 which are currently the most common model of team-based PHC delivery (Leslie et al. 2020). An eight-year *Trilateral Master Agreement* (2003-2011) was signed between the Alberta Medical Association (AMA), the Ministry of Health (MoH), and AHS to develop the PCNs (AMA 2004). PCN membership requires AHS and family physicians to sign a contract agreeing to identify local priorities and collaboratively develop programs and services (Leslie et al. 2020). Physicians can continue billing the MoH on a fee-for-service (FFS) basis, and have full responsibility over resource allocation (IPHCPR 2022). While some PCNs primarily service Indigenous communities, First Nations communities do not have a direct relationship with the PCNs (IPHCPR 2022). The 2008 Primary Care Initiative Policy Manual was jointly developed to monitor the implementation and evaluation of PCNs (Government of Alberta 2018). Overall, PCNs have successfully piloted several local Indigenous health-focused projects, but continue to face challenges with accountability and quality control (Government of Alberta 2018). Furthermore, in a 2016 PCN review, feedback shared from physicians indicated a need to update the FFS compensation model to a community or activity-funding model, which would allow for increased community-based program development (Montesanti et al. 2022). Today, PCNs provide minimal services to some on-reserve First Nation communities (IPHCPR 2022).

Recognizing a need to better support Indigenous health, the Aboriginal Health Transition Fund (AHTF) was released in 2005, supported by $200 million of funding. The *Working Together to Improve Aboriginal Access to Health* document shares that the AHTF aimed to develop long-term partnerships to improve health service integration and Indige-

nous health outcomes (Health Canada 2010). A total of 34 projects were funded in Alberta from 2005-2011, all of which established community partnerships (Health Canada 2010). For instance, one AHTF project was to establish an inter-jurisdictional deliberation process which enabled AHS to extend mobile cancer screening services to communities in the Western Cree Tribal Council (Health Canada 2010).

Building on the success of the AHTF, the federal government launched the Health Services Integration Fund (HSIF), investing over $80 million for time-limited Indigenous health innovation projects (Government of Canada 2020).[5] In Alberta, planning for HSIF has been achieved through collaborative processes, such as HCoM (Kargard 2012). Representatives from various stakeholder groups joined forces to advance the concept for an approved project entitled *Provincial Support for Integrated Primary Care Programs On-Reserve* (Whiteduck Consulting Ltd. 2012). Projects were piloted across four sites: Kee Tas Kee Now Tribal Council, Siksika Health and Wellness, Western Cree Tribal Council, and Yellowhead Tribal Council. The biggest project lesson shared was that HSIF opened the doors to demonstrate how relational work with communities can enhance First Nations health overall (HSIF PC Project Management Team 2016). However, there were several barriers to implementation, including challenges with partnership development, timely communication, and jurisdictional issues highlighted in the *Lessons Learned Manual* (HSIF PC Project Management Team 2016). While funding these PHC projects was critical to supporting First Nations health, it is important to note that funding is typically provided to communities with the capacity and resources to sustain such projects. Moreover, recipients for HSIF only included First Nations communities and organizations, which meant that Inuit and Métis were ineligible for this funding. This perpetuates inequities for non-First Nation communities, as well as those with less human-power and fewer local support structures to carry-out pilot projects.

Furthermore, the 2014 *Alberta Primary Health Care Strategy* was released at a pivotal time where leadership changed at the provincial level (Government of Alberta 2014). Of relevance to this review was the strategy's vision to: (1) enhance delivery of care through service integration and co-ordination; and (2) establish building blocks for change, including effective governance for the PHC system, added supports for the PHC workforce, and involving the community in planning and delivering PHC services (Government of Alberta 2014). While it envisioned PHC reform in the province, this strategy had no provisions for Indigenous PHC.

3.5 Indigenous-focused PHC reform

Since the early 2000s, several Indigenous-focused PHC reform initiatives have been implemented, driven by local action, and aimed at addressing gaps in health services delivery. In response to economic concerns surrounding diabetes management for Indigenous communities, the Aboriginal Diabetes Initiative (ADI) was co-developed with Indigenous peoples

[5]HSIF was re-launched from 2018-2021 and again in 2021 (ISC 2020).

(IPHCPR 2022). The ADI received a total of $523 million in funding over three project phases (Public Health Agency of Canada 2005; Health Canada 2011). A First Nations and Inuit health region was established in Alberta, affording Indigenous communities and organizations the opportunity to submit proposals to fund community-based programming (Leung 2016). Among programs funded was the Indigenous (formerly Aboriginal) Diabetes Wellness Program in Edmonton, which provides holistic diabetes care (Crowshoe et al. 2021). This program was delivered through a Clinical Alternative Relationship Plan (ARP) model, enabling physician renumeration through the provision of defined primary care services rather than through a FFS model (Alberta Health 2014).

The success of the Indigenous Diabetes Wellness program led to the creation of the Indigenous Wellness Program Clinical Alternative Relationship Plan (IWPCARP) in 2011, initially grant funded and now under a ministerial order (IPHCPR 2022). The IWPCARP pays physicians to provide PHC to First Nation community health centres, with work underway to expand services to Métis settlements. The model was first used at two Indigenous-led health centres: the Elbow River Healing Lodge (Calgary), established in 2008, and the Indigenous Wellness Clinic (Edmonton), established in 2010 (IPHCPR 2022). Today, the IWPCARP provides renumeration to physicians who provide PHC services to about half of the 45 Indigenous communities (IPHCPR 2022). Predating the IWPCARP is the Siksika First Nation Alternative Relationship Plan, established in 2009 and extended through to 2023. Communities were not directly involved in any of the negotiations surrounding the Alternative Relationship Plan development and thus, were not signatories on the agreement (IPHCPR 2022).

To demonstrate commitments to provide more comprehensive health services for First Nations, several memoranda of understanding (MOUs) were signed by First Nations and AHS between 2009-2012 (IPHCPR 2022). Unlike many other initiatives that are imposed on Indigenous communities, memorandums of understanding are supported by Nations and demonstrate intentions to develop respectful relationships (IPHCPR 2022). Although not formal policies, MOUs are part of the broader policy agenda and can open doors for future policy initiatives and enhanced relationships.

AHS further supports Indigenous health priorities through the work of the Indigenous Wellness Core (IWC), a team guided by the *Indigenous Health Commitments: Roadmap to Wellness* (AHS 2020). This roadmap describes the structures, processes, and organizational changes needed to achieve health equity for Indigenous peoples (AHS 2020). The IWC has conducted several listening days with stakeholders to discuss how the team can best address gaps in Indigenous PHC (IPHCPR 2022). These listening days guided the creation of the Roadmap to Wellness (IPHCPR 2022).

In 2018, the federal government, the Government of Alberta, and the First Nations Health Consortium (comprised of 11 Nations) signed the *Memorandum of Understanding on Implementation of Jordan's Principle in Alberta* to ensure that First Nations children in Alberta can access supports and services they need, when they need them (Government of Alberta 2018). The MOU allows all signatory parties to address gaps and share in-

formation ensuring that children and families in Alberta are receiving necessary supports, including mental health, medical equipment, and educational supports. Despite strides towards the implementation of Jordan's Principle in Alberta, chronic underfunding of services, resources, and infrastructure in First Nations communities by federal and provincial governments has prevented advancements in health equity for all First Nations children (IPHCPR 2022). Sadly, the federal government continues to fight Jordan's Principle, demonstrating a national failure to protect Indigenous rights (IPHCPR 2022).

4 IMPLEMENTATION

As previously mentioned, the Policy Triangle and Ripples Framework were used to extract key information from the reviewed policies. The Policy Triangle supported understanding of how actors, content, context, and process shape policies. Use of the Ripples Framework guided interpretation of the degree to which Indigenous peoples have been engaged in health policy development to-date, and what is needed to ensure increased participation in decision-making. Drawing on these frameworks, there are some key implementation considerations which may guide future decision-making and policy analyses.

Within Indigenous PHC policy development, there is considerable information that remains undocumented. The engagement of key actors who have been directly involved in decision-making, planning, or implementation of policy developments can help unearth policy stories and contextualize information surrounding key policy events. On this thread, it is key to consider the value of informal policy documents. MOUs, memos, and manuals can provide critical context surrounding policy decisions and paint the broader policy development story.

It is evident that PHC for Indigenous communities has had minimal political attention and continues to be chronically underfunded; unfortunately, changes in government leadership can jeopardize the limited funding and resources available to communities. To mitigate this possibility, Indigenous peoples need to be represented at all decision-making tables and embedded in policies and programs. Indigenous representation is key to ensuring Indigenous health needs remain a priority in ways that communities would like to see actualized. Increasing the uptake of Indigenous-led PHC models would further promote sustainability of PHC policies and programs.

Many of the policies reviewed were targeted towards First Nations on- and off-reserve, sidelining the health needs of Métis, Inuit, and non-status Indigenous peoples. Additionally, many policies highlighted the ongoing jurisdictional challenges surrounding roles and responsibilities of various stakeholders within Indigenous PHC policy. Calls for distinctions-based approaches to health that recognize the specific rights, interests, and concerns of each Indigenous group is integral to achieving health equity for all Indigenous peoples, especially for Métis and non-status Indigenous peoples. However, realizations of distinctions-based health care may continue to be hindered by historical policy decisions noted in the findings

of this policy analysis.

5 EVALUATION

The impact of many of these reforms remains unclear, with the lack of comprehensive evaluations in the area of Indigenous health. It is evident that PHC policies with the greatest impact (i.e., success among Indigenous communities) are those that have emerged from local action and have led to the creation of specific advancements to meet Indigenous needs, such as the ADI and IWPCARP. These initiatives stand alone as they are not aligned with provincial policy directions that provide minimal support for Indigenous PHC. Unfortunately, these policies and programs do not reflect strategic initiatives at the provincial level, where support for Indigenous health remains minimal. For example, Indigenous health is not a core mandate of PCNs, and this is evident by the absence of organizational actions, structures, and governance models to address Indigenous health inequities. Provincially, Indigenous PHC services should be governed by policies that are based on insights elicited from previous policy evaluations and learnings to better support Indigenous health priorities.

Federal initiatives supported by significant funding have sufficient resources to complete comprehensive evaluations, compared to local initiatives where capacity is limited. The summative evaluation report on the IHTP, *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report*, was released in 2006. The evaluation found that the IHTP led to improvements in health care access and overall health outcomes (Health Canada 2006). It also found ongoing challenges with mechanisms for funding allocation, challenges with resource expenditure for First Nations and Inuit health organizations, and a lack of clarity in the roles and responsibilities between Indigenous organizations, the province, and FNIHB (Health Canada 2006). Similarly, the outcomes from the PHCTF pilot project in Bigstone Cree Nation are unclear, as there is limited evaluative data on the results of this pilot project. While HSIF enabled the creation of community driven PHC projects, the *Lessons Learned Manual* shared barriers around funding limitations and inconsistencies, as well as jurisdictional complexities. More broadly, jurisdictional challenges have been pervasive because of policies being imposed on Indigenous peoples without their engagement in the creation, implementation, and evaluation of the policies and a comprehensive understanding of their policy priorities. To address the existing gaps, Indigenous peoples should be engaged in all stages of policy-making, to define which indicators and metrics are of importance and which benchmarks would be indicative of a policy implementation success to them.

Progress towards achieving PHC equity with Indigenous peoples is shaped by past policy legacies that set future path dependency. Today, improvements in Indigenous PHC are shaped by Indigenous peoples' relationship with the federal government as defined by the *Indian Act*. Over the last six decades, shifts within Indigenous PHC policy have revealed

tensions between this relationship, mainly centred on the federal government's financial responsibilities for Indigenous health care. It began with the federal government's control over Indigenous peoples' rights until the mid-1960s, to devolving their responsibilities and passing control to Indigenous peoples in the late 1960s, in an attempt to get out of the business of health care. In the late 1970s, the government reaffirmed their role in providing health care to Indigenous peoples and their responsibility in strengthening collaboration. This led to large-scale, funded reforms such as the PHCTF, AHTF, HSIF, and initiatives to increase Indigenous participation in decision-making, like HCoM. Despite all these efforts, Indigenous peoples seeking PHC still fall through the cracks because funding initiatives have not resulted in fundamental structural changes in PHC for Indigenous peoples. While current-day, Indigenous PHC-focused policy reforms have seen some success, future policy reforms need to prioritize strategic and systemic restructuring that ensures negotiated accountabilities among federal, provincial, and local partners as formal agreements. From this, future policies can emerge that will serve to strengthen Indigenous PHC and advance health equity.

6 STRENGTHS, WEAKNESSES, OPPORTUNITIES, THREATS

The SWOT analysis (Table 1) is based on our in-depth, retrospective policy analysis of the policies that have shaped Indigenous PHC in Alberta over the last several decades. We summarize the strengths and weaknesses of these policies in advancing Indigenous PHC, the opportunities that exist, and the threats that remain.

Table 1: SWOT Analysis

Strengths	Weaknesses
• Policies supported with significant funding enabled the creation of several PHC programs/services in Alberta. • Many present-day reforms are the result of Indigenous-driven efforts.	• Many of the policies reviewed did not develop timelines for action or plans for evaluation. • Older reforms lacked or had minimal Indigenous engagement, and these policies have legacies.
Opportunities	**Threats**
• Indigenous engagement in the conception, delivery, implementation, and evaluation of PHC policies, programs, and services. • Increased adoption of Indigenous-led models. • Indigenous representation at all relevant decision-making tables in matters concerning their health.	• The jurisdictional disputes between federal and provincial governments can create obstacles in best supporting Indigenous health needs. • Changes to government leadership and funding can negatively impact policies and programs already in place.

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8 APPENDIX 1

List of reviewed policies

Policy Title	Policy Type	Year	Publisher	Author
The Context of Delivery of Health Services to Status Indians and Inuit by Medical Services Branch	memo	1988	FNIHB (Medical Services Branch)	FNIHB (Medical Services Branch)
Statement of the Government of Canada on Indian Policy (*The White Paper*)	decision	1969	Government of Canada	Government of Canada
Citizens Plus (*The Red Paper*)	counter-policy report	1970	Indian Chiefs of Alberta	Indian Chiefs of Alberta
Indian Health Policy	decision	1979	Health Canada (Department of National Health and Welfare)	Health Canada (Department of National Health and Welfare)
Memorandum of Understanding between the Minister of National Health and Welfare and the Treasury Board Concerning the Transfer of Health Services to Indian Control	decision	1989	Treasury Board of Canada	Minister of National Health and Welfare; Treasury Board of Canada
Rainbow Report	plan	1989	National Library of Canada	Premier's Commission on the Health of Future Albertans
Refocused Role of Medical Services Branch	statement	1996	FNIHB (Medical Services Branch)	FNIHB (Medical Services Branch)
Regional Health Authorities Act (Bill 20)	legislation	1994	Legislative Assembly of Alberta	Legislative Assembly of Alberta
Interchange Canada's Special Interchange Agreement for Medical Services Branch, Health and Welfare Canada	agreement	1995	Interchange Canada	Interchange Canada
Health Co-Management Terms of Reference	agreement	1996	HCoM	HCoM
Indian Health Policy Transfer Implementation Handbooks 1-3	plan	1999	FNIHB (Department of National Health and Welfare)	FNIHB (Department of National Health and Welfare)
Primary Health Care Transition Fund Initiative	decision	2000	Government of Canada	Government of Canada
Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements	agreement	2003	AMA	AHS, AMA, MoH
Primary Care Initiative Policy Manual	manual	2008	GoA	AHS, AMA, GoA
Working Together to Improve Aboriginal Access to Health	decision	2005	Health Canada	Health Canada
Health Services Integration Fund	decision	2011	ISC	ISC
Health Services Integration Fund: Lessons Learned Manual	manual	n.d.	HSIF PC Project Management Team	HSIF PC Project Management Team

Provincial Support for Integrated Primary Care On-Reserve	inventory report	2012	Whiteduck Consulting Ltd.	Whiteduck Consulting Ltd.
Alberta's Primary Health Care Strategy	strategy	2014	GoA	Alberta Health, GoA
Memorandum of Understanding between Alberta Health Services and Tribal Chief Ventures Inc.	MOU	2009	AHS	Tribal Chief Ventures Inc., AHS
Memorandum of Understanding between Alberta Health Services and North Peace Tribal Council	MOU	2010	AHS	North Peace Tribal Council, AHS
Memorandum of Understanding between Alberta Health Services and Blood Tribe of Health	MOU	2011	AHS	Blood Tribe of Health, AHS
Memorandum of Understanding between Alberta Health Services and Siksika Health Services	MOU	2011	AHS	Siksika Health Services, AHS