RESEARCH PAPER

First Nations Health Networks: A Collaborative System Approach to Health Transfer

Réseaux santé des Premières nations : approche collaborative pour le transfert des services de santé

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Abstract

The Health Transfer Policy (HTP) of Health Canada's First Nations and Inuit Health Branch (FNIHB) offers First Nations the opportunity to assume a degree of administrative control over community-based health services. Although shortcomings

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of the policy have been documented, certain elements, particularly second- ("zone") and third- ("regional") level transfer (Health Canada 2001), have provided First Nations the flexibility to create novel organizations. These First Nations Health Networks (FNHNs), which have emerged through grassroots movements and inter-jurisdictional processes, have brought together a number of communities under a planning body, tribal council or health authority.

The authors discuss the concept of First Nations Health Networks as variously implemented across Canada. In this study, the FNHNs may be defined as health authorities, fall under the auspices of a tribal council or be limited to a planning instrument. Yet, they all aspire to similar principles: cooperation, collaboration and sharing, under a consensus of optimizing health resources (Warry 1998). The authors explore these health management entities, look at their perceived strengths and challenges and identify key issues that may define the inherent risks and benefits or illuminate best practices for the benefit of other First Nation groups considering such a collaborative undertaking.

The paper begins with a discussion of the emergence of the FNHN concept, followed by detailed case studies of six collaborative First Nation initiatives. The third section explores common themes, regional differences and jurisdictional challenges faced by these organizations. The authors conclude with an exploration of the FNHN as a health management concept and recommendations for further analysis.

Résumé

La Politique sur le transfert des services de santé de la Direction générale de la santé des Premières nations et des Inuits offre aux Premières nations la possibilité d'assumer un certain contrôle administratif sur les services de santé communautaires. Bien que les lacunes de la politique aient été documentées, certains éléments – notamment les transferts aux deuxième (« zone ») et troisième (« région ») niveaux – ont permis aux Premières nations de créer de nouveaux organismes. Ces réseaux santé des Premières nations (RSPN), qui ont vu le jour grâce à la mobilisation populaire et à des collaborations interrégionales, réunissent plusieurs communautés sous un même centre de planification, sous un même conseil tribal ou encore sous une même autorité sanitaire.

Les auteurs décrivent le concept des RSPN comme étant très varié au Canada. Dans cette étude, les RSPN sont définis soit comme des autorités sanitaires, soit comme des entités sous l'égide des conseils tribaux ou soit simplement comme des centres de planification. Cependant, ils adhèrent tous à des principes semblables, c'est-à-dire la collaboration et le partage, dans une volonté commune d'optimisation des ressources sanitaires (Warry 1998). Les auteurs étudient ces organisations de gestion de la santé, examinent leurs forces et les défis auxquels elles font face, cernent les

principaux enjeux en matière de risques et d'avantages et dégagent les meilleures pratiques au profit d'autres groupes des Premières nations intéressés à mettre en place un tel système de collaboration.

L'article débute par une description de l'émergence du concept des RSPN. Il se poursuit par l'étude de cas détaillée de six initiatives des Premières nations. Puis, dans la troisième section, il fait état de thèmes communs, de différences régionales et de défis administratifs pour ces organisations. En conclusion, les auteurs abordent le concept de gestion de la santé propre aux RSPN et formulent des recommandations pour d'éventuelles analyses.

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The Health Transfer Policy (HTP) was introduced in Parliament in 1987, with the stated intent of offering eligible First Nations and Inuit communities a degree of control over community health services (National Health and Welfare and Treasury Board of Canada 1989), previously delivered by the Medical Services Branch of Canada's Department of Health and Welfare (now the First Nations and Inuit Health Branch of Health Canada, or FNIHB). While most First Nations can apply for health transfer under the policy, only those Inuit communities located in Labrador are eligible.

The transfer of health services control from FNIHB to First Nations and Inuit communities arguably offers a significant opportunity for enhancement of local capacity and culturally appropriate health planning and delivery. First Nations and Inuit groups have widely sought to take advantage of it; as of September 2006, a total of 160 transfer agreements, representing 279 First Nations and Inuit communities (or 46% of eligible communities) have been signed (Health Canada 2006). Such transfer agreements may include any or all of the three tiers of FNIHB healthcare: first level (community – direct service delivery), second level (zone – coordination, supervisory) and third level (regional – consultant, advisory). A fourth level, headquarters services, remains the exclusive purview of FNIHB (Lavoie et al. 2005).

Since this policy was first introduced, different approaches have emerged across the country. One such approach has been the development of collaborative networks involving a number of First Nation communities, often organized through affiliation with tribal councils or health authorities. Multiple communities joining together have the opportunity to share available expertise and ensure an efficient use of resources (Lemchuk-Favel 1999).

Transfer hinged on the idea of transferring pre-existing services that were located in the community (Level 1), zone (where they existed; Level 2) and region (Level 3), and were identified as transferable to First Nation or Inuit communities. Assuming responsibility for second- and third-level services may expand opportunities for First Nations to develop a more systemic approach to their healthcare planning and deliv-

ery. The resources allocated for the transfer of community-based services are based on historical expenditures. With regard to second- and third-level services, establishing and recruiting for a partial position, or finding support for partially funded roles, are tasks that tend to be impractical for most communities (Lavoie et al. 2005). FNHNs enable the pooling of financial resources, thereby improving opportunities to sustain second- and third-level services. Similarly, support for transferred positions may require cooperation and coordination at a higher level, having previously been the function of FNIHB. If such services are to be taken on through transfer, one mitigating strategy is the development of a collaborative system such as the FNHN. These agencies are able to combine their communities' resources strategically to plan, deploy and evaluate these elements of healthcare.

One challenge arising from these features of the HTP has been termed the "residual role" of FNIHB, which may potentially result in conflict and confusion between FNIHB and FNHNs. With flexible negotiation processes between First Nations and the various FNIHB zones and regions, each health transfer agreement can potentially result in a different set of second- and third-level services and, thereby, varied expectations for the First Nation. Thus, FNIHB and its staff may be left with a different residual role for each individual agreement. This patchwork of residual roles may lead to a lack of consistency in the relationship between the FNHN and its primary founder (Lavoie et al. 2005: 55–56).

The concept of the FNHN is not new. In a discussion paper written for the Royal Commission on Aboriginal Peoples, O'Neil (1993) recommended the recognition of collaborative networks as the "central building blocks for a progressive Aboriginal health service," further suggesting that they could provide the foundation for potential provincial or national Aboriginal health institutions, or both. Such organizations would receive block funding – i.e., revenue combined from federal, provincial and other sources – which they would allocate according to locally established priorities.

The Assembly of First Nations, in its 2005 Health Blueprint submission to the Aboriginal Roundtable, further suggested "First Nations Health Authorities" as the potential building blocks of a proposed "distinct yet interdependent" First Nation Health System, thus largely echoing O'Neil's earlier recommendation (AFN 2005: 4).

The FNHN idea has not been without its critics. Small, independent First Nations are often advised by FNIHB to join an FNHN in order to make transfer viable, even if they lack natural alignment of a service-delivery, cultural or political nature with such an organization (Sommerfeld and Payne 2004).

Methodology

This study is based on a series of interviews conducted with six FNHNs across

Canada. The criteria used in the identification of potential FNHN participant organizations were based on the following defining characteristics:

1. First Nation organizations (and/or their member communities) that had signed, or were in the process of signing, a health transfer agreement with FNIHB;
2. A First Nation–governed agency that had pre-existed, been formed or proposed to support the planning, administration and/or delivery of health services in multiple First Nation communities; and
3. Delivery or proposed delivery of health services primarily by the organization and/or its affiliated communities (i.e., not by Health Canada or other non–First Nation entities), chiefly to local on-reserve populations. Provincial services may also have been delivered in concert with federally funded healthcare programs.

Ethics approval for the research and methodology was granted by the Queen's University General Research Ethics Board in November 2004.

A national scan was conducted through consultation with academics, federal government and Aboriginal organization representatives, as well as Internet and literature searches, to identify potential participant agencies. Once these were identified, health directors or executive directors of appropriate agencies were contacted in order to solicit participation in the study. Ten organizations were contacted, of which six agreed to participate. The study, interview and ethics protocols were reviewed with health directors or executive directors as part of the consent process. None required that ethical approval be pursued with another organization. Informed consent was obtained through a letter of information and consent form. Data gathering consisted of a one-hour telephone interview using a set questionnaire covering topics of governance, administrative structure and supports, funding, staffing and self-perceived organizational strengths and weaknesses.

A total of seven individual, semi-structured interviews were conducted by telephone at the convenience of the participants. In the case of one organization, two representatives were interviewed. The interview guide was provided to participants in advance and consisted of standard questions exploring the following areas:

- Description of the FNHN, its model, management and governance structure;
- Development of the FNHN and its relationship to partner communities;
- Integration with other services, e.g., social services, provincial healthcare;
- Quality assurance measures, health outcomes and staff satisfaction measures;
- Funding and cross-jurisdictional relationships, including barriers to cooperation;
- Strengths, weaknesses, challenges and potential remedies; and
- Advice to other potential FNHNs.

Most participants in the research volunteered that they were of First Nation ancestry; many also had backgrounds in a healthcare profession. All held senior positions (e.g., executive director, health director) in their respective organizations. A profile of the collaborating organizations is shown in Table 1.

TABLE 1. Organizational profiles

First Nations Health Network	Location	Cultural affiliation	Number of communities	Average population per community	Services
Inter-Tribal Health Authority (ITHA) (ITHA informant #1, personal communication, February 25, 2005; ITHA informant #2, personal communication, March 18, 2005)	Nanaimo, BC	Coast Salish and Kwakiutl	29	528 14 FN <500	Primary care, prevention and secondary supports
Northern Inter-Tribal Health Authority (NITHA) (NITHA informant, personal communication, February 1, 2005)	Prince Albert, SK	Plains Cree, Woodland Cree, Dakota, Dene	32	1,559 1 FN <500	Advisory support to community-based services offering primary, secondary and tertiary prevention interventions as well as treatment.
Dilico (District Liaison Council) (Dilico informant, Personal communication, March 18, 2005)	Thunder Bay, ON	Ojibwe	13	922 2 FN <500	Primary care, prevention and secondary interventions (provincial – mental health, child welfare)
Matawa First Nation Tribal Council (MTC) (MTC informant, personal communication, March 3, 2005)	Thunder Bay, ON	Cree, Ojibwe	10	917 2 FN <500	Secondary prevention and supports (e.g., diabetes)
Wabun Tribal Council (WTC) Health (Wabun informant, personal communication, March 15, 2005)	Timmins, ON	Cree, Ojibwe	6 year-round + 1 summer only	370 4 FN <500	Primary care, secondary supports and some tertiary prevention (provincial long-term care)
Tui'kn Initiative (Tui'kn informant, personal communication, March 15, 2005)	Eskasoni, NS	Mi'kmaq	6	1,360 0 FN <500	Primary prevention (provincial primary care)

Source: INAC 2000, 1997.

Using the FNHN as a case study, a qualitative design was adopted, as described for health services environments by Keen and Packwood (1995). The interview transcript was subjected to content analysis in order to identify patterns of those factors most commonly cited by informants as playing a significant role in the development, governance and ongoing operations of their FNHN. These factors were then grouped and analyzed for commonalities and differences, and this framework was then checked against the literature. As required, follow-up by telephone or e-mail was conducted in order to clarify interview data. A copy of the final report was provided to the six participant FNHNs.

Findings

The six organizations described in Table 1 are, in many ways, as diverse as the communities, the cultures and the land in which they operate. They emerged largely in isolation by navigating through their own unique needs and challenges, some by strong internal partnerships, others by a collegial process with FNIHB. No two cases were alike owing to a number of factors, including unique program funding opportunities, jurisdictional issues, clinical program development and individual community capacity and participation. The interviews and case study analysis did, however, reveal a number of common themes that were identified by the key informants as significant in their efforts to plan, administer and provide services with their partner communities: the relationship with FNIHB (including its "residual role"), funding and administrative issues, culturally appropriate care and processes, and community development and knowledge transfer. As most informants requested anonymity prior to their interview, no names have been divulged, and the organizations have been identified only in cases where disclosures were accepted through the participant's express written consent.

Relationship with FNIHB

The relationship with FNIHB, the primary funder, was clearly identified in the interviews as an important factor to the FNHN. Informants cited the FNIHB's aforementioned residual role as a challenge. One FNHN discovered it was being seen by local First Nations as the replacement for FNIHB yet had to confront the difficulties inherent in losing FNIHB capacity, such as knowledge transfer, Community Health Representative training and nursing supports. As liaison with the federal government, another FNHN informant reported a sense of inadvertently inheriting the mistrust and blame normally directed by First Nations at the federal government, to the point where the FNHN's representatives were equated with the notorious "Indian agents" by their own stakeholders. The Indian agent, who was the historically appointed feder-

al government community representative, was once responsible for virtually all aspects of the administration of Indian Affairs, which included a role in the provision of basic medical care (as keepers of the community's "medicine chest"). The agents have been described as "all powerful" and responsible for executing policies "designed to facilitate the protection, civilization and assimilation" of First Nation individuals (Waldram et al. 2006: 187–88).

One participant described the "double-edged sword" scenario in which FNIHB representatives took a hands-off approach with the FNHN, leaving it to manage risks and opportunities. This experience speaks at least partially to a reduced residual role for FNIHB in a post-transfer environment. Other informants, however, reported excellent working relationships with their FNIHB contacts, generally characterized by open communication and mutual respect.

While the residual role of FNIHB may be in decline, its presence remains. The 2005 National Evaluation of the Health Transfer Policy identified that FNIHB could require 60 or more reports annually from a First Nation (Lavoie et al. 2005: 47), relevant to HTP and other funding transfers.

Administrative and funding issues

The efforts of FNHNs to administer Non-Insured Health Benefits – those FNIHB-funded extended health benefits, such as eyeglasses and prescription drugs (not available through standard provincial coverage) – were frequently hampered by arduous eligibility criteria and inadequate funding. In some cases, funding for such benefits, previously negotiated through a health transfer agreement, had been returned to FNIHB as it was found insufficient to meet the service needs of the FNHN's communities. Recruitment challenges were commonly noted related to funding factors such as the "no escalation" clause of the HTP, which freezes funding at levels negotiated through the original health transfer agreement. These constraints put FNHNs in competition for scarce health human resources against the superior salaries and benefits offered by provincial and federal unionized employers.

"Mandatory programs" (i.e., those prescriptive FNIHB services mandated to First Nations through their health transfer agreement) also presented challenges in that such programs do not necessarily align with the community health priorities identified in the locally developed Community Health Plan (CHP), a required component of the HTP. Furthermore, informants suggested that FNIHB has imposed new priority programs without consultation with the First Nation, or consideration of fit with the CHP. Meanwhile, other priority needs voiced by the community, such as traditional healing services, are often ineligible for HTP funding.

Nevertheless, there was a hope that services supporting local priorities could be provided through savings associated with the economies of scale and greater budget-

ary flexibility of a larger healthcare organization. Similarly, although "no escalation" means that HTP funding is based on the original CHP, the FNHN model expands opportunities to shift funds between budget lines, according to changing health needs. However, because of the "no escalation" clause, fund-shifting often involves reduced spending on administration or second- or third-level services in favour of front-line, community-based services.

Culturally appropriate care and processes

A common struggle for a number of the participants in their attempt to offer holistic healthcare was the lack of sustainable, comprehensive mental health services. Informants noted that small-scale mental health funding programs, coupled with the great need for services in their communities, create challenges in developing and supporting appropriate mental healthcare. While mental health funding is available from a number of FNIHB and Indian and Northern Affairs proposal-based programs (Aboriginal Healing Foundation, Brighter Futures, Building Healthy Communities), each has a different mandate and provides inadequate amounts of funding, even with considerable FNHN economies of scale. With mental health and addictions being among the greatest issues facing First Nations, a sustainable, comprehensive, flexible program would appear to be of the utmost priority.

Several informants mentioned a desire to make their programs and services relevant to their First Nation service users. One FNHN had proposed developing a new model based on the time-honoured trapping tradition of its constituents and attempting to translate its values and principles to a regional health delivery milieu. This approach signifies a way in which FNHNs can bring culturally oriented thinking to their individual context, rather than the more uniform approach of FNIHB. As a liaison between FNIHB and the community, the FNHN would then introduce a layer of flexibility in policy and practice. In this case, a benefit of this flexibility is a stronger connection between health delivery and the culture of the partner First Nations.

One agency noted that the CHP process, as designed by FNIHB, is not one in which community members can adequately participate. The FNHN has instead developed its own planning and evaluation methods, which use a traditional storytelling format to facilitate input and participation from service users. One respondent referred to this approach as "adapting our own way of knowing" rather than enforcing academic or provider-centric perspectives.

Knowledge transfer and community development

Best practices can also be shared through the FNHN. The Tui'kn Initiative, which

builds on the prior success of the Eskasoni Health Centre (EHC), aims to implement the EHC's multi-jurisdictional collaborative model of care in another five local First Nations, thereby breaking down barriers to accessing care (Tui'kn informant, personal communication, March 15, 2005).

Similarly, an informant from the Northern Inter-Tribal Health Authority (NITHA) noted that a great deal of invaluable knowledge transfer has occurred between the partners (personal communication, February 1, 2005). The four NITHA First Nation partners have developed strengths through delivery of their individual second-level programs and through their collaborative governance of NITHA's third-level services.

All informants spoke of the substantial numbers of staff of Aboriginal origin employed by their health networks. Similarly, their boards, being composed of community chiefs and other First Nation officials, could be seen as role models and a source of inspiration for their communities. A Dilico informant (personal communication, March 18, 2005) reported that the organization has become a "rallying point for the region" through its successful administration and delivery of provincially and federally funded health and social programs. The leadership skills and abilities developed by those involved in management, governance and program delivery of the FNHN contributed significantly to other efforts in community and professional development.

The success of Dilico in providing high-quality healthcare to the community, as verified by its accreditation by the Canadian Council on Health Services Accreditation, was reportedly due, in part at least, to the lessons learned and capacity developed in their initial experiences providing provincial child welfare services. Further, in providing child welfare services to Aboriginal children on- and off-reserve, the organization became aware of the two-tiered nature of service delivery, and resolved to provide services that were both culturally appropriate and comparable in quality with non-Aboriginal programs, while also advocating for improvements to the broader determinants of health, such as income and housing.

Discussion and Conclusions

It is evident that, while the First Nations Health Network is, first and foremost, a health management model, it brings other benefits to its leadership and to the communities it represents. Most participants in the research mentioned the value of community development in bringing confidence, strength and knowledge to First Nations. This benefit was particularly significant where an atmosphere of multi-jurisdictional collaboration could be established. As illustrated by the experience of Tui'kn/EHC and Dilico, the combined efforts of First Nations, provincial and federal governments and other sectors can bring a result that – through a broader range of services, multi-partite support and flexibility in funding – is greater than the sum of its parts.

Provinces, health authorities and other non-Aboriginal health and social service bodies need to be included in these developments in order to provide the holistic, multidisciplinary primary healthcare continuum that most Canadians take for granted.

The case of the FNHN, however, provides an alternative perspective on the shortcomings of FNIHB's Health Transfer Policy. FNHNs are able to mitigate some of the policy's weaknesses through their liaison role and their ability to confer advantages such as economies of scale. They remain, nevertheless, heavily challenged by the funding and administrative constraints imposed on them by the HTP. FNHNs may offer the potential for a unique, community-based approach to healthcare planning, administration and delivery for First Nations, but will be unable to succeed fully without significant modifications to the federal Health Transfer Policy.

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