

## Restructuring First Nations Health Governance: A Multilevel Solution to a Multifaceted Problem

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### Abstract

*This paper investigates current health governance structures as a contributing factor to the disproportionate burden of ill-health and inequitable health service delivery experienced by First Nations communities. A review of the contemporary and historical context sets the stage for the analysis, outlining health status, social determinants of health and the policy framework within which health inequities are situated. The paper proceeds with a critical analysis of power imbalances perpetuated within Canada's health care system in the form of barriers such as inadequate health services, fragmented governance, jurisdictional gaps and lack of government accountability. The discussion explores self-determination as a means of empowering First Nations communities to take control of the design, delivery and evaluation of health care services and ultimately, reclaim control of their health and wellbeing. Four models of self-government are evaluated to highlight several key features of a sustainable framework, including: recognition of autonomy, a voluntary process, an opt-in/opt-out provision, protection by legislation and the support of a fiduciary relationship with the State. Finally, a multilevel mosaic model of self-government is proposed as a pragmatic framework that is adaptable to the varying needs and capacities of First Nations communities.*

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## I. INTRODUCTION

**W**ITHIN CANADA, a country highly acclaimed for its universal health care and national values of democracy, equality and freedom, it is paradoxical that Indigenous peoples experience a disproportionate burden of ill-health and inequitable access to health services. Although many inequities are common among Indigenous groups, this paper will focus on the challenges faced by First Nations, without dismissing the similar experiences of Métis and Inuit. The problem is multifaceted and has three distinct but interrelated components. At a population level, the problem is especially evident in the disparity in health status between First Nations and Canada's general population, as demonstrated by the comparative prevalence of chronic conditions outlined in the First Nations Regional Longitudinal Health Survey (as cited in Health Canada, 2008). This paper will also link health inequities to a more systemic problem in the form of fragmented governance, jurisdictional gaps, and lack of government accountability. Furthermore, these issues can be attributed, in part, to entrenched power imbalances that marginalize First Nations people within Canada's system of health governance. At the root of the issue is a political relationship defined by exclusion from federal divisions of power and paternalistic power dynamics that maintain federal control over resources (Ladner, 2009).

To address current health inequities and counter power imbalances, First Nations communities are attempting to re-establish and redefine their position within the Canadian state, and further reclaim and revitalize self-determination through control over local government and health care. This paper will explore various models of self-government to identify essential elements of a functional governing structure. Key factors that will be considered in each of these models

include control over resources, as well as flexibility to accommodate the unique needs of communities and account for varying levels of human, financial and infrastructure capacity. Ultimately, restructuring Canada's health care system and government structure to incorporate a system of First Nations self-government that facilitates local control over health services would have the dual benefit of improving access to culturally appropriate health services and addressing inequities in health status for First Nations people.

## II. HEALTH INEQUITIES

There is a distinct disparity in the overall health statuses of First Nations populations and the general Canadian population. The burden of health issues prevalent within many First Nations communities is commonly compared to "Third World health status" (Matthew Coon Come, as cited in Adelson, 2005), which is deplorable considering that Canada is ranked fourth out of 177 countries in the 2007-2008 United Nations Human Development Index (Health Canada, 2008). Although the gap is narrowing as a result of increased public awareness and concern, persistent disparities remain between First Nations people and other Canadians. This section will highlight some of the critical health inequities and their sources to establish the problem in quantitative terms.

Some of the most pressing health concerns facing First Nations communities include: mental health, diabetes, obesity, cancer, respiratory disease, dental health, HIV/AIDS, addictions and children's health (Adelson, 2005; Health Canada, 2008; First Nations Health Council, 2011; Loppie Reading & Wien, 2009). These health concerns are exacerbated by their cumulative effect on quality of life as well as their connection to various determinants of health. As mentioned above, the First Nations Regional Longitudinal Health Survey documents some of the most alarming statistics, including: 36% of First Nations adults living on-reserve are considered to be obese compared to the national prevalence rate of 24%; diabetes prevalence among First Nations adults living on-reserve is approximately 20% – four times

the rate of the general population; and First Nations adults account for more than 27% of all reported positive HIV, although they are estimated to make up only 6% of the population (as cited in Health Canada, 2008). Although the statistics representing the health status of First Nations are startling, what is perhaps even more unsettling is the fact that these conditions are preventable at a systems level. Critically analyzing the sources of these health issues reveals that the problem could be prevented, mitigated and, with the application of appropriate strategies, eliminated.

The various health issues that impact First Nations communities stem from a range of historical, social and political determinants. The intricacies and interconnections between these determinants of health can be best understood through a model presented by Charlotte Reading and Fred Wien (2009), which categorizes determinants as distal, intermediate, or proximal. Through this lens, Reading and Wien link health concerns such as obesity, diabetes, and HIV to proximal determinants that influence health in direct ways such as health behaviours, physical and social environments. Proximal determinants are in turn connected to and affected by intermediate determinants that have more of an indirect impact on the health of individuals, such as community infrastructure, resources and structural racism. Finally, intermediate determinants are further linked to distal determinants, including historic, political, social and economic contexts. Distal determinants frame the broader context or “bigger picture” within which all other determinants and health issues are situated and thus have the most profound impact on First Nations health and wellbeing. Some of the most significant distal determinants that embody the root cause of health inequities among First Nations people include: colonization, loss of sovereignty, dispossession of traditional lands, the imposed reserve system, residential schools and destruction of culture. These historical, social and political factors have persisted through time and across multiple generations, adversely influencing the health status of First Nations people for over a century. Moreover, “individuals, communities and nations that experience inequalities in the social determinants of health not only carry

an additional burden of health problems, but they are often restricted from access to resources that might ameliorate problems” (Reading & Wien, p.2). This injustice effectively demonstrates that key determinants of health and variations in health are intimately linked to power relations in society. Exploring the shortfalls of Canada’s health care system reveals that inequities exist not only in First Nations health status, but also in the delivery of health services to First Nations people and their access to health care.

## 1. First Nations health governance

In order to set the context of the current inequitable conditions within First Nations communities, this section will briefly summarize the systems, structures and relationships that influence health through the various determinants of health. First Nations health governance is situated within a complex political relationship with the State (formerly the Crown) and is formalized by various policies that establish the basic terms and conditions of the relationship. The terms of the relationship started with the signing of original treaties between the Crown and some – but not all – First Nations in and around the nineteenth century (Mackinnon, 2005). Health care was considered a treaty right, afforded to First Nations people living on-reserve, and the Crown was entrusted with the responsibility for delivering health services as part of its fiduciary duty to First Nations people. In 1867, the British North America (BNA) Act – the foundation of the Canadian Constitution – set forth the division of powers and defined jurisdictional boundaries for Canadian federalism. It stipulates “Indian affairs,” including “Indians and the lands reserved for Indians” as a federal jurisdiction (Section 91[24]) and health care, alongside social services and education, as a provincial jurisdiction (Kelly, 2011; First Nations Health Council, 2011), thus creating ambiguity over the provision of health care to First Nations people that remains today. The Indian Act of 1876 provides no specific clarity for First Nations health

governance.<sup>1</sup> Although it was enacted to regulate and monitor the system of band council governments, it does not define jurisdictional responsibility for the provision of health services for First Nations – on-reserve or otherwise. Together, these policies complicate First Nations health care and make the health system difficult to navigate.

Because of the complex policy framework, First Nations people receive health services through a unique combination of federal, provincial and First Nations-run programs and services. In practice, the provinces are responsible for providing all aspects of health services to all residents, including First Nations living on- and off-reserve, through provincial networks of clinics, hospitals and other treatment facilities (Government of British Columbia, 2005). The federal government, through the First Nations and Inuit Health (FNIH) Branch, delivers primary health, public health and health promotion services to First Nations reserve communities and Inuit communities; FNIH also provides ancillary health services (e.g. drug and dental) to First Nations people (with status) on and off-reserve (Health Canada, 2011). However, the federal government restricts its responsibility for health care provision to “on-reserve,” leaving the provincial governments to cover health care for Métis as well as First Nations and Inuit peoples living off-reserve (Laurel Lemchuk-Favel, 2004, p. 37). The federal government “aims to” provide services on-reserve comparable to that the provinces provide to non-First Nations within their jurisdiction (First Nations Health Council, 2010). These complicated jurisdictional divisions indirectly affect inequities in health status by creating barriers to access to health care for First Nations people.

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<sup>1</sup>A “Band” or “Indian Band” is a First Nations governing body on-reserve instituted by the Indian Act, 1876. The Indian Act defines a “band” as “a body of Indians a) for whose use and benefit in common, lands, the legal title to which is vested in Her Majesty, have been set apart; b) has funds held for it by the federal government and c) is declared a band by the Governor-in-Council” (as cited in First Nations Studies Program, 2009).

## 2. Systemic barriers

The current structure of health care in Canada creates unnecessary and inequitable barriers for First Nations people to overcome in order to access basic health services that are taken for granted by the general Canadian population. For many First Nations, health services are not always available or accessible; and when they are, they tend to be inadequate, ineffective, or underfunded (Adelson, 2005). First Nations people face obstacles such as geographic isolation – particularly in northern and remote communities – language barriers, lack of culturally appropriate services, scarceness of First Nations health providers, lack of community involvement in the administration of health services, as well as discrimination and institutional racism within mainstream systems of care (Hirsch, 2011; Reading & Wien, 2009). These barriers often produce distrust and discourage First Nations people from accessing health services, even when they are available. While the challenges listed above are circumstantial and vary across geographic areas, First Nations communities, and individual experiences, as a collective, First Nations face several systemic barriers that are entrenched within Canada's health care system. This section will discuss the impacts of barriers such as fragmented governance, jurisdictional gaps, and lack of government accountability, which act as intermediate determinants of health.

One of the main challenges impeding access to health care for First Nations is the fragmented governance structure that is divided between federal, provincial and in some cases, local governments. The National Collaborating Centre for Aboriginal Health frames the challenging organization of the Canadian health system as “a complex patchwork of policies, legislation and relationships... Further complicating the system is the multiplicity of authorities who are responsible for health services and programs: the federal, provincial/territorial and municipal governments; various Aboriginal authorities; and the private sector” (2011, p.1). The lack of intergovernmental coordination and the failure to harmonize federal and provincial health policies often results in overlaps and duplication of services (Mackinnon, 2005; Webster, 2009). Moreover, despite the range

of actors involved in delivering health services to First Nations, complete coverage is not guaranteed; rather, the lack of accountability among federal and provincial governments creates jurisdictional gaps and piecemeal coverage.

An intrinsic feature of the uncoordinated, fragmented system of First Nations health governance is a longstanding debate between federal, provincial and First Nations governments in terms of who is responsible for health care for First Nations people. The jurisdictional boundaries outlined by the BNA Act may be clear in theory, but they have proven to be ambiguous and convoluted in practice. The divisions not only exist across tiers of government, but also translate to divisions across ancestry, place of residence and land claim agreements. As a result, disparities and inconsistencies are present both between First Nations and the general population, and also within Indigenous populations (Kelly, 2011). Jurisdictional ambiguity has allowed both levels of government to minimize responsibility for First Nations health services, “continually [seeking] ways in which the other government will pay the costs of services” (Mackinnon, 2005, p. 14). The federal government has never acknowledged a legal obligation to provide health care services to First Nations and has increasingly distanced itself from service provision by transferring responsibility to the provinces and First Nations, under the auspices of supporting community control and autonomy (Kelly, 2011). These jurisdictional divisions and disjunctions are products of an overarching government structure and system of hierarchy designed to maintain colonial power and privilege.

### 3. Power imbalances

To delve further into the root causes of health inequities, this section will briefly discuss a couple major distal determinants that influence health through broader political, social and historical factors. Specifically, the underlying power dynamics between First Nations and the State are of primary relevance to health governance. First Nations health governance is situated within Canada’s two-tiered



federal system, whereby jurisdiction and control over resources are divided exclusively between federal and provincial levels of government. Within this system, First Nations and municipal governments do not share formal status as federal partners. In fact, First Nations were explicitly excluded during the creation of the federation: “no Aboriginal representatives were invited to the Charlottetown or Quebec conferences of 1864, where the foundations of the Canadian federation were established” (Papillon, 2010, p.246). Under the BNA Act of 1867, First Nations people became subjects of federal jurisdiction and therefore, subjected to governmental-dependency (p. 245), divided – like everything else in Canada – between federal and provincial jurisdictions. As an extension of explicit denial of status as federal partners, First Nations governments have no inherent or constitutionally defined jurisdictions or responsibilities, no decision-making ability that is not subject to the authority of the federal government and no ability to generate revenue or to create financial capacity to operate as a government (Ladner, 2009). These restrictions limit communities’ ability to express self-determination and further entrench a power imbalance between First Nations and the State.

Not only does the two-tiered system of federalism instill inequity through paternalistic power dynamics, but it is based in illegitimate claims to sovereignty.<sup>2</sup> Just as federalism was forced upon First Nations people without their consent, state sovereignty was unilaterally imposed by the Canadian government and its colonial predecessor, the Crown. European settlers used the notion of Terra Nullius, or “empty land,” which applies Lockean concepts of land ownership to claim that because Indigenous peoples did not work the land, they therefore did not possess title to the land.<sup>3</sup> Even though

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<sup>2</sup>Parliament of Canada defines sovereignty as “supreme legitimate authority within a territory... Supreme authority within a territory implies both undisputed supremacy over the land’s inhabitants and independence from unwanted intervention by an outside authority” (Philpott, 1995 as cited in Carnaghan & Goody, 2006).

<sup>3</sup>Title refers to the inherent Indigenous right to land or a territory; “...This right is not granted from an external source but is a result of [Indigenous] peoples’ own occupation of and relationship with their home territories as well as their ongoing social structures and political and legal systems...” (First Nations Studies Program, 2009).

the State no longer defends this logic, they do not question it as a flawed source of sovereignty, thus maintaining power imbalances (Tully, 1999). By refusing to address the question of title, the State disregards First Nations' sovereignty and denies their inherent right to self-determination, which originates from pre-contact. Prior to colonization, First Nations governed themselves with their own governing structures and systems of law, sustained by their lands and resources. At no point during colonization (contact, treaties, confederation or beyond) have they ceded their autonomy as sovereign nations or subjected themselves to the colonial powers of foreign authorities — be they French, British, or Canadian (Ladner, 2009). Therefore, the State has no legal grounds to assert a claim of jurisdiction over or to govern First Nations or their lands. Together, these arguments against illegitimate State sovereignty and the flawed health care system form the basis of my proposal in favor of self-governance.

### III. RESTRUCTURING FIRST NATIONS HEALTH GOVERNANCE

#### 1. Self-governance

Central to most proposals for restructuring First Nations health governance is establishing a system of self-governance as a basis for healing. In its final report, the Royal Commission on Aboriginal Peoples (1996) proposed a comprehensive “action plan for moving forward,” which advocates for self-government as a means of empowering Indigenous communities to plan and manage their own health systems, among other responsibilities such as managing their own resources, taxing their citizens and making their own laws. First Nations' inherent right to self-determination, stemming from unceded sovereignty, is reaffirmed and entrenched by both the Canadian Constitution in Section 35(1) and the United Nations Declaration of Indigenous Rights. Recognition of these rights is limited in scope and undermined by paternalistic power dynamics. In order for First Nations people to exercise full control over their lives and their health,

the health system and structure of government need to be fundamentally restructured to accommodate and promote self-governance. First Nations communities need to redefine and reposition their place within the institutionalized system of health governance, reclaiming control over both local government and health care. Self-governance would give First Nations communities authority over policy-making, program planning, service delivery and monitoring of health outcomes (Hirsch, 2011).

Numerous authors link self-governance and self-determination with improved health among First Nations people through various correlations, such as the removal of physical and perceived barriers, improved access to health care, increased number of culturally appropriate services and greater control of resources (Chandler & Lalonde, 1998; Hirsch, 2011; Labonte, 1994; Ladner, 2009; Reading & Wien, 2009; National Collaborating Centre for Aboriginal Health, 2011). A key argument for self-government is that First Nations people are better positioned to identify their own health concerns and priorities and thus create solutions. By managing and delivering healthcare in their communities, First Nations governments are empowered to increase community awareness of health issues, deliver more culturally informed health care, improve employment opportunities for community members and ultimately improve the community's health status (National Collaborating Centre for Aboriginal Health, 2011, p.3). Reading and Wien suggest that self-determination is, in fact, the most important determinant because it influences all other determinants, including education, housing, safety and health education (2009, p.23). This multilevel approach to health inequities is crucial because it encompasses proximal, intermediate and distal determinants of health, and accounts for unique local needs.

## 2. Models of self-government

While it is commonly understood that self-governance is a positive development towards the health and wellbeing of First Nations, an ideal model of self-determination is far from reality for many of these

communities; this is in part due to barriers established by the State (as described above) and also due to lack of consensus on what constitutes an ideal— and practical— model of self-government. Various frameworks of self-governance have been proposed and are being deployed within provinces, regions and communities. A few models in particular have shown potential for broader implementation; however, their strengths and weaknesses have to be further analyzed to determine what the future of health governance and self-governance should look like.

## **2.1 Health transfer policy**

Within Canada's health care system there is a current model of "transfer arrangements" that facilitates the decentralization of some health care administration to First Nations governments under the Health Transfer Policy. While health transfer arrangements do not equate with self-determination, increased control over decisions related to health policies, programs and services is a fundamental step towards self-governance for many First Nations communities. Since 1989, Health Canada, through the FNIH, has offered First Nations governments the option of entering agreements or transfer arrangements that delegate responsibility for some or most health services, which would otherwise be delivered by the federal government, such as public health services (First Nations Health Council, 2011). Funding for these programs and services is provided through a variety of agreements which vary in terms of level of control, flexibility and accountability (Government of British Columbia, 2005).

Many band councils have opted for transfer arrangements to increase their control over health service delivery. BC has the highest percentage of First Nations communities involved in health transfer in Canada, with over 80% of the 203 communities involved in some form of transfer (First Nations Health Council, 2011, p.21). The level of control exercised by these First Nations governments ranges from direct control over all decisions relating to health policies, programs and services to merely having a role in implementation with little or no control over decision-making (Chandler & Lalonde, 1998, p. 14).

Long term evaluations reported positive results among communities involved in the health transfer policy (Health Canada, 2013). Among the reported findings are: the objectives of transfer have been realized at the community level for communities that entered the post-transfer phase; community members had an increased awareness of health issues and health care had become more of a priority in transferred communities; social and community development strategies were found to be in place using a variety of culturally informed and relevant methods of health delivery; and community health services were found to be integrated with other programs and services such as social services, mental health, home care, education and non-insured health benefits. These outcomes reaffirm the potential benefits of local control over health care; however, the scope of this evaluation is limited because it only reports on health transfer arrangements, which represent a narrow conception of self-government.

While many communities have benefitted from increased control over health care through health transfer arrangements, the model has several flaws. In addition to the positive results reported in the evaluation, First Nations communities noted some critical concerns with the transfer process, including adversarial relationships with the federal government, lack of clarity regarding the various roles each would occupy, the government's rigid approach to negotiation and unresolved jurisdictional issues between the provincial governments and the federal government (Health Canada, 2013). Naomi Adelson (2005) calls attention to the "fatal flaw" in the health transfer policy, in that it perpetuates the pre-existing relationship of dependence by maintaining federal control over resources. Even though First Nations governments have been delegated much administrative responsibility for federal programs, the federal government still exercises control through financial transfers, departmental administrative and accountability requirements, the use of third party management and its ability to override all bylaws (Webster, 2009). Within many First Nations communities, health transfer arrangements only give an illusion of increased control over health care, as bands simply administer federal programs without the capacity, resources and autonomy to be

fully self-determining.

## **2.2 Tripartite Framework Agreement**

A new and innovative approach to health governance has recently been established in British Columbia, where a 10-year agreement has been negotiated with the federal government that transfers administration of First Nations health care to a new provincial health governance structure specific to First Nations people. The new governing body consists of the First Nations Health Authority (FNHA), the Tripartite Committee on First Nations Health, the First Nations Health Directors Association and the First Nations Health Council. The policy change was formally set into motion on October 2011 with the signing of the BC Tripartite Framework Agreement on First Nation Health Governance (Tripartite Framework Agreement); and on October 1st 2013, Health Canada officially transferred its jurisdiction over health programming and services for BC First Nations to the FNHA (Health Canada, 2013). The FNHA assumes responsibility for the planning, design, management and delivery of health programs for BC First Nations, while the federal government will continue funding the programs over the 10-year agreement, with additional support from the BC government (Health Canada, 2011). The FNHA was established to serve the purpose of a decentralized governing body that represents BC First Nations— both in terms of leadership and mandate. The FNHA is community-based and locally accountable, offering a platform for First Nations communities and individuals to influence health governance as an expression of self-determination.

The Tripartite Framework Agreement is a first in Canada and represents a historic transformation of health governance for First Nations. The federal government may adopt this framework as a national model of First Nations health governance, if proven to be effective. O’Neil (2013) explains, “If successful, the transfer would provide a template — and a pool of experts — for First Nations leaders elsewhere in Canada who are closely watching the B.C. experiment.” This new health governance structure has the potential to improve health inequities and address service gaps experienced by BC First Nations

by integrating health programs to create a more effective and efficient health system (Health Canada, 2013). Furthermore, the FNHA is better positioned to represent the needs, priorities and cultures of BC First Nations by incorporating cultural knowledge, beliefs, values and models of healing into the design and delivery of health programs (Health Canada, 2011). By responding to the unique needs of BC First Nations, the decentralized system of health governance can help promote healthy, self-determining First Nations communities.

The new provincial health governance structure has the potential to transform health care for BC First Nations; however, the model has a few critical limitations. First, the FNHA is aimed primarily at “Status” First Nations living on-reserve in BC.<sup>4</sup> The Tripartite Framework Agreement does not include any explicit statement indicating inclusion of non-Status First Nations, First Nations living off-reserve, First Nations living outside BC, Inuit or Métis. Moreover, the new framework has limited potential for empowerment and self-determination. Although it gives greater power to BC First Nations to influence health governance through the First Nations Health Authority, the agreement explicitly states that it shall not have the effect of or be interpreted as a self-government agreement (Health Canada, 2011). This condition significantly limits First Nations communities’ ability to assume full control over their health through self-determination. Furthermore, it maintains present power imbalances between First Nations and the federal government by reinforcing the State’s exclusive sovereignty.

### **2.3 Third order of government**

A third model of self-government that offers First Nations governments more substantial control over health care and addresses issues of dependency through capacity building is the establishment of a third order of government. As discussed above, there are only two

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<sup>4</sup> “Indian Status” refers to a legal identity assigned to Canadian Aboriginals (First Nations, Métis and Inuit) by the Canadian government. Section 6 of the Indian Act outlines criteria for who is legally considered an “Indian”, thus defining who qualifies for “Indian status” (as cited in First Nations Studies Program, 2009).

formal tiers of government within Canada's system of federalism: federal and provincial. Restructuring federalism to include a third tier of government would offer First Nations governments jurisdictional power parallel to the federal and provincial governments rather than being subordinate. In their final report, the Royal Commission of Aboriginal Peoples proposed the development of a third order of government as an imperative action for First Nations to reclaim control of their lands and livelihoods (Aboriginal Affairs and Northern Development Canada, 2010). Recognition as an equal federal partner and government authority would be a significant achievement for First Nations people in terms of both self-governance and health governance.

A third order of government would empower First Nations governments to manage their own resources, tax their citizens, make their own laws, use traditional systems of government and justice and provide health and social services that meet the needs of their communities without interference from federal or provincial bodies. Under this model, First Nations would be viewed as distinct political entities entering unique government-to-government relationships with mutual respect for sovereignty (Hirsch, 2011). The autonomy promised under this model aligns with Chandler and Lalonde's definition of self-government as, "negotiations with federal and provincial governments in having further established their right in law to a large measure of economic and political independence within their traditional territory" (1998, p.14). Unlike the Health Transfer Policy or the Tripartite Framework Agreement, a third order of government offers First Nations governments legitimate autonomy to be self-determining. Furthermore, this framework would empower First Nations communities to rediscover and reinstate traditional concepts of health, healing knowledge and health systems, which already exist in Indigenous knowledge and continue to exist in some semblance or another despite years of colonial decay.

A third order of government may offer a more effective model of self-government and control over health care than the Health Transfer Policy or the Tripartite Framework Agreement, but it is still sub-



ject to limitations. A fundamental oversight in this framework is the assumption that communities have the human, financial and infrastructure capacity to substantiate increased jurisdictional powers. Across Canada, First Nations communities have distinct cultures, histories, traditions and beliefs; they are also diverse in terms of geographic location, size, economic base, capacity and access to resources. Because of this diversity, a one-size-fits-all approach is inadequate to accommodate the unique needs of First Nations people. It would be a futile endeavor to implement a system of First Nations self-governance unless issues of capacity are adequately addressed.

#### **2.4 Health self-governance — multilevel mosaic**

A promising model of health governance and self-governance exists in the US, where “health self-governance” has been mandated by the federal government. Through the Indian Self-Determination and Education Assistance Act (Public Law 93-638) of 1975 [ISDEAA], Tribes can voluntarily opt into one of two different options for health self-governance: 1) remain within the federal health system, or 2) take a combination of delivery systems depending on their needs and abilities. If the Tribes wish, they can retrocede or return responsibilities for specific program areas back to the federal government (First Nations Health Council, 2011, p.35). In this case, the decisions to contract or not to contract are equal expressions of self-determination. This particular model features several key characteristics that make it a suitable framework for Indigenous peoples both in the US and in Canada, including: recognition of autonomy, a voluntary process, an opt-in/ opt-out provision, protection by legislation and the support of a fiduciary relationship with the federal government. These features provide a relevant guide for the development of a national model of health governance and self-governance within Canada.

The US’s system of health self-governance aligns with principles of the “multilevel mosaic” model of self-government proposed by Martin Papillon (2010), which could be implemented as a national framework of First Nations self-government and also guide the decentralization of health governance to communities seeking greater auton-

omy. Similar to a formal third order of government, this model would offer First Nations increased autonomy in the form of self-government; however, it resembles the US IDEA approach by accounting for cultural diversity, varying levels of capacity and unique local needs. The multilevel mosaic model also accommodates the lack of uniformity among First Nations communities, “as [their] context, status, needs and expectations as well as political clout... vary considerably” (Papillon, 2010, p. 248). Under this framework, jurisdiction over health care and other public service areas (e.g. social services, education and justice) would be devolved to First Nations communities in a way that would be proportional to their capacity to exercise self-governance. Larger, more developed communities that are rich in resources could reasonably have status equal to a third order of government, whereas smaller communities that require further capacity development would receive additional assistance from federal and provincial governments. In all cases, First Nations governments would have the option of assuming greater control over the planning and delivery of health services, though the organization and structure of the local health systems would be unique to each community.

When compared to the other models of self-government discussed above, a multilevel mosaic model stands out as the most promising framework for restructuring First Nations health governance. The strengths and weaknesses of each model can be evaluated using the notions of proximal, intermediate and distal determinants of health discussed earlier (Reading & Wien, 2009). Both the Health Transfer Policy and the Tripartite Framework Agreement primarily address proximal and intermediate determinants by increasing First Nations’ control over the delivery of health services, but are limited in their ability to address distal determinants because they perpetuate structural and colonial power imbalances. On the other hand, the third order of government challenges some of the most significant distal determinants by revitalizing self-determination; however, the model’s emphasis on the “bigger problem” overshadows important proximal and intermediate determinants such as community capacity, infrastructure, and resources. Finally, the multilevel mosaic model addresses

all three in tandem by empowering First Nations to take control over their health and wellbeing, their health governance, and their relationship with other levels of government. In this sense, the multilevel mosaic model offers a multilevel solution for a multifaceted problem.

### 3. Recommendations

Through these discussions and evaluations of the four models of self-government presented above, it becomes evident that a multilevel mosaic model is the most pragmatic approach to applying self-governance as a solution to current health inequities. Reflecting on the framework's potential to simultaneously influence proximal, intermediate and distal determinants of health, I recommend it as a blueprint and guideline for the restructuring of First Nations health governance. This reform is not merely an ideal, but an imperative, and demands immediate action. Due to its complex nature, the reform will require the support and long-term commitment of all levels of government (including First Nations and local governments), all sectors and all individuals implicated by health inequities, policy-making, and colonial power imbalances. The multilevel mosaic model requires further research and, more importantly, extensive consultation and collaboration with First Nations to identify a clear vision for health governance and self-governance. In order for a multilevel mosaic model of health self-governance to function, terms and conditions of the arrangement would have to be negotiated within each First Nations community. The new approach would require intense local or regional negotiation between First Nations, federal and provincial or territorial governments; the pace at which these negotiations proceed would ultimately be up to First Nations communities to determine. This process would, of course, take time and require ongoing collaboration and capacity development. Nonetheless, establishing a framework of health self-governance that devolves power and resources proportionally to communities' capacity and needs is essential to serving the diverse health needs of First Nations people.

#### IV. CONCLUSION

Canada's existing health care system and government structure must be fundamentally reframed to facilitate an increase in First Nations' control over health services. This transformation has been shown to have positive effects on the health and wellbeing of First Nations communities and is an essential step towards fixing the complex problems embedded within First Nations health governance. The current health status and system of health governance for First Nations communities represents inequities that are unacceptable in terms of the disproportionate distribution of barriers and challenges across populations as well as preventable with respect to social and political issues stemming from historical and contemporary determinants of health. At the root of the issue is a flawed policy framework and political relationship that perpetuate power imbalances. Within the current health system, First Nations people face barriers such as inadequate health services, fragmented governance, jurisdictional gaps and lack of government accountability. This system stems from an overarching governing structure, whereby First Nations governments are excluded from federal divisions of power and subject to paternalistic relations that are maintained through federal control over resources.

Self-determination has been identified as a solution to many of the health challenges facing First Nations communities. By establishing control over local governance and health care, First Nations governments can empower their communities to reclaim control of their health and wellbeing. Various models of self-government exist, each offering benefits and challenges for First Nations health governance. While the Health Transfer Policy offers First Nations governments increased control over the administration of health care at the local level, it perpetuates the paternalistic relationship between the Canadian state and First Nations people by maintaining federal control over resources. Similarly, the Tripartite Framework Agreement empowers First Nations people to play a more significant leadership role in provincial health governance, but does not translate to self-governance for local communities. While the third order of govern-

ment model empowers First Nations governments to revitalize self-determination as sovereign nations, its one-size-fits-all approach fails to account for different levels of capacity among nations. Finally, a multilevel mosaic model of health self-governance offers increased control over local governance and health care in such a way that is proportional to communities' capacities and needs, while respecting First Nations' collective right to self-determination and upholding Canada's fiduciary relationship to First Nations people. Implementing a multilevel mosaic model of health self-governance would fundamentally require reconsidering and restructuring colonial power dynamics entrenched within Canada's system of health care and structure of government, but could potentially have profound benefits for the overall health of Canada's First Nations population. This reform is significant not only to First Nations, but to Canada as a whole, which has a moral responsibility, a fiduciary duty, and in some cases a treaty obligation to address current health inequities.

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