Exploring Shifts in Indigenous Primary Health Care Policy Development in Alberta, Canada: A Case Study Analysis

by

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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 across the globe. In the province of Alberta, Canada, varying degrees of PHC services exist within First Nations, Métis, and urban contexts that are fragmented, under-resourced, and disconnected from each other, exacerbating existing health inequities. This thesis research aimed to explore historical and present-day policy shifts or changes that have shaped Indigenous PHC delivery in Alberta; and examine the engagement of Indigenous peoples in PHC policy and decision-making. Prior to and into the early 1960s, the federal government assumed financial responsibilities and decision-making for First Nations and Inuit health. However, by the end of the decade, the federal government attempted to devolve their responsibilities to First Nation and Inuit to reduce their fiduciary role in health care delivery and relationship with Indigenous peoples. Fast forward to the late 1970s, the government re-affirmed their responsibilities in providing health care to First Nations and Inuit, which led to the creation of many co-designed policy reforms and initiatives provincially to increase Indigenous participation in health policy throughout the 2000s. However, more concerted efforts are needed to ensure that health priorities of importance to Indigenous peoples are appropriately addressed. Future health policy reforms can improve Indigenous peoples' health experiences and promote health equity by strengthening the coordination and delivery of PHC services.

PREFACE

This thesis is an original work by Danika Riva Goveas (DRG). Throughout the thesis, "Indigenous" is used only when statements apply to all Indigenous groups: First Nations, Inuit, and Métis. However, it is important to note that this term overlooks the diversity of cultures, languages, and historical experiences of each population. Additionally, "Indian" and "Aboriginal" are used only in reference to historical use of these terms in policy documents.

The thesis is paper-based and includes one manuscript in Chapter 4 that has been submitted for publication to a peer-reviewed journal. The manuscript was submitted for publication as Goveas, D., Montesanti, S., Chatwood, S., Crowshoe, L. "Examining Policy Shifts and Transformations in Indigenous Primary Health Care in Alberta, Canada." *Health Reform Observer, McMaster University Library Press*. The student (DRG) was the primary author on the manuscript included in this thesis, which was co-authored by her supervisor, Dr. Stephanie Montesanti (SM), and her thesis advisory committee members, Dr. Susan Chatwood (SC) and Dr. Lynden (Lindsay) Crowshoe (LC). The student (DRG) worked closely with SM to develop the methods (policy analysis) and to collect the primary qualitative data. DRG conducted data analysis and SM supported interpretation of the findings. DRG was responsible for drafting the manuscript and SM reviewed the manuscript to strengthen each section. SM, SC, and LC provided critical feedback on the draft manuscript.

This thesis is divided into five chapters. Chapter one introduced Indigenous peoples, their health care experiences, and the context of PHC in Canada and Alberta. Chapter two describes the policy problem and research objectives. Chapter three provides an overview of the methods used. Chapter four describes the results of this research. Chapter five discusses the implications of the research findings for policy and practice, as well as recommendations for future research.

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To my chosen family, I am endlessly grateful to all of you wonderful humans for your unwavering support of my aspirations. To my brothers, I love you both and thank you for being there whenever I needed to take a break from work. I am especially indebted to my parents, Rehanna and John Goveas. Mama and Dada, I love you both very much and thank God every day for blessing me with the most adoring, hardworking, and inspiring parents who always push me to be better.

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Graduate school can be hard at times and often feels isolating. The love and support of my community is what grounded and nurtured me over the course of this journey. I share this accomplishment with all of you.

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LIST OF ABBREVIATIONS

CHA: Canada Health Act

FNIHB: First Nations and Inuit Health Branch

FNIHB-AB: First Nation Inuit Health Branch – Alberta

ISC: Indigenous Services Canada

IPHCPR: Indigenous Primary Health Care and Policy Research

IWPCARP: Indigenous Wellness Program Clinical Alternative Relationship Plan

MSB: Medical Services Branch

NCCIH: National Collaborating Centre for Indigenous Health

PCN: Primary Care Network

TB: Tuberculosis

TRC: Truth and Reconciliation Commission of Canada

CHAPTER 1: INTRODUCTION

Indigenous peoples in Canada

Indigenous peoples, comprising of First Nations, Inuit, and Métis, represent 5% of the population living on the land presently known as Canada (Statistics Canada, 2022). These Peoples encompass diverse cultural and linguistic groups with rich histories, traditions, and strong ties to Ancestral lands. Indigenous peoples have been resilient in the face of profound forces of colonization, exerting resistance and surviving to be among the oldest living cultures in the world (Mitchell, 2019; Smallwood et al., 2021).

Colonial policies have disrupted Indigenous peoples' experiences of good health, which remain below that of the general population (Mitchell, 2019). In Canada, Indigenous peoples have a lower life expectancy at birth (Public Health Agency of Canada, 2016), a trend that is also observed among Indigenous populations worldwide (Anderson et al., 2016). Indigenous peoples experience a disproportionate burden of non-communicable diseases compared to their non-Indigenous counterparts (Statistics Canada, 2015). For instance, a population-based cohort study of nearly three million people in Alberta, Canada, found that the lifetime risk of developing diabetes was higher among First Nations compared to the general population, with approximately eight out of every ten First Nations predicted to develop diabetes in their lifetime (Turin, 2016). Ensuring access to comprehensive primary health care (PHC) services is widely accepted as key to improving health outcomes (Hutchinson et al., 2011; Spooner et al., 2021; van Weel, 2018). Unfortunately, in Canada, progress towards achieving PHC equity with Indigenous peoples is hindered by historical relations and policy choices that set future path dependency on policy transformations on Indigenous peoples' health.

Overview of Health Care Delivery in Canada

The foundation of health care in Canada dates back to *The Constitution Act* of 1867 (formally the British North American Act), where section 92 (7) grants provinces exclusive jurisdiction in "establishing, maintaining and managing hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals" (Health Canada, 2019, p. 1). A province-wide, universal hospital patient care plan was established in Saskatchewan in 1947, with British Columbia and Alberta adopting similar plans in 1950 (Health Canada, 2019). It was later expanded to include medical care (mainly defined as hospital and physician services) in 1962 (Health Canada, 2019). Services were resourced by a provincial tax-financed plan. The federal government played a part in the emergence of universal health coverage through its spending power, which it continues to use to maintain national standards for universal health coverage (Health Canada, 2019). Through the encouragement of the federal government, universal public health insurance was later adopted by the rest of the country. In Alberta, a universal health insurance program was adopted in 1969 (Health Canada, 2019).

In 1966, the federal government passed the *Medical Care Act,* offering to "reimburse, or cost share, one-half of provincial and territorial costs for medical services provided by a doctor outside hospitals" (Health Canada, 2019, p. 1). The *Medical Care Act* stipulated that Indians would also be expected to access services through their provincial plan and would be expected to apply to their province of residence for financial assistance with co-payments and premiums (Health Canada, 2019). Later, in 1984, the *Canada Health Act* (CHA) was passed, replacing the federal hospital and medical insurance acts (Health Canada, 2019). Under the CHA, provincial and territorial governments are responsible for the delivery of *universally accessible* and *publicly insured* health care services (Government of Canada, 2023). Indigenous peoples were entitled to access these services as residents of those provinces or territories (Indigenous Services Canada, 2023a). Unfortunately, Indigenous peoples do not have equitable access to health care services covered by the CHA because of geographical location, health system deficiencies, and inadequate health human resources in many communities (Marchildon et al., 2020; National Collaborating Centre for Indigenous Health [NCCIH], 2014). For instance, for Indigenous peoples residing in rural and remote parts of the country, transport to urban centres is often required to access medically necessary health care services (Nader et al., 2017). In Nunavut, a largely Indigenous territory, 58% of patients who require inpatient or outpatient health care services are transported outside of the territory (Canadian Institute for Health Information, 2010). Similarly in Alberta, hospitals in rural and remote communities often lack the resources and capacity to treat severe cases, requiring transportation of these cases to hospitals in larger urban centres, such as Edmonton or Calgary (McLane et al., 2021; Nader et al., 2017). As such, the CHA fails to meet the needs and constitutional rights of Indigenous peoples (Martin et al., 2018). Ultimately, the responsibility for Indigenous health care delivery has historically been fragmented, complicated by differences in health coverage between First Nations, Inuit, and Métis peoples, and differences in services offered between provinces. This has resulted in a patchwork of health services for Indigenous peoples across the country (NCCIH, 2011).

Overview of Health Care for Indigenous Peoples in Canada

Historical Relationship between Indigenous Peoples' and the Crown

Historical relations between Indigenous peoples and the Crown include a number of key defining moments. Under *The Constitution Act* (1867), treaties signed between First Nations (formerly referred to as Indians) and Canada were formally established, deeming First Nations a federal responsibility (Lavoie, 2013; Boyer & Spence, 2015). The supreme court later decided that Inuit would also be considered "Indians" under *The Constitution Act* and thereby, would also be considered federal responsibility (Lavoie, 2013). For many years, Métis were caught in a jurisdictional limbo, with neither federal nor provincial governments claiming responsibility (*Daniels v. Canada, 2016*). Advocacy from Métis leader Harry Daniels prior to the patriation of the Constitution Act in 1982 was a strong attempt at expanding Indian rights to include Métis; however, political leaders were ultimately not committed to including Métis under the Constitution (Indigenous Peoples Atlas of Canada, 2018). However, through the 2016 landmark case of *Daniels v. Canada*, the Supreme Court declared that Métis and non-status First Nations would be considered "Indians" under the revised *Constitution Act* of 1982 (*Daniels v. Canada, 2016*; Lavoie, 2018). As such, *The Constitution Act* (1982) now recognises all three groups: Indians (First Nations), Inuit, and Métis. In parallel, the Crown signed treaties with First Nations peoples in the late 19th century; of particular interest for this research are Treaty No. 6 (1876), Treaty No. 7 (1877), and Treaty No. 8 (1899). Treaty No. 6 includes the "Medicine Chest Clause" which states "that a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent" (Crown-Indigenous Relations and Northern Affairs Canada, 1964). Furthermore, despite constitutional recognition of their "existing aboriginal and treaty rights" (Section 35 of the Constitution Act 1982), First Nations, Inuit, and Métis live with constitutional and legal divisions; the most important of which for First Nations is the 1876 *Indian Act*. The *Indian Act* was established by the federal government to administer Indian status (for First Nations), local First Nations governments, and manage reserve lands (Section 35 of the Constitution Act 1982). Many colonial laws under the *Indian Act* were aimed at assimilating First Nations into Euro-Canadian society and eliminating First Nations culture (Section 35 of the Constitution Act 1982). Status under the *Indian Act* places individuals and First Nation communities in a relationship with the federal government unlike that of any other population group in Canada.

Jurisdictional Responsibilities over Indigenous Health

A national Department of Health was established by the federal government in 1919, eventually adopting the name Health Canada in 1993. Health Canada oversees federal jurisdictions in health care and supports services governed by the CHA (Health Canada, 2021). Within Health Canada, the First Nations and Inuit Health Branch (FNIHB) (previously the Medical Services Branch) was housed, with aims to support the delivery of health services to First Nations on-reserve and Inuit communities (Henry, 2021). FNIHB has a decentralized structure, consisting of a national office and regional offices. In Alberta, FNIHB-AB manages both the First Nations (on-reserve) and Inuit Health Envelopes (Henry, 2021).

FNIHB now falls under Indigenous Services Canada (ISC), established in 2017. ISC provides funding and health care services for First Nations (on-reserve) and funds community health programs across Inuit Nunangat (the homeland of Inuit in Canada) (ISC, 2023a). Additionally, ISC funds the Non-Insured Health Care benefits program to “eligible First Nations and recognized Inuit” across the country (ISC, 2023a). ISC does not have a mandate to provide services for Métis, First Nations off-reserve, and non-status First Nations; therefore, services and benefits are primarily provided directly through provinces and territories for these groups (ISC, 2023a). Unfortunately, the roles and responsibilities of the various levels of government in the provision of health care services remains ever shifting, resulting in poorly coordinated service delivery and health care gaps for Indigenous peoples (ISC, 2023a; Lavoie, 2013).

Brief History of Indigenous Peoples Health Care Experiences

Historical Health Care Experiences

Instances of health care violence, including inadequate provision of health resources, medical experimentation on, and abuse towards Indigenous peoples, have been prominent throughout history. In the late 1870s, First Nations across the country suffered from widespread famine, largely due to the collapse of bison herds (Daschuk, 2013; Logan McCallum, 2017; Wildcat, 2015). The poor response from the "Canadian state" to supply food rations led to the rapid emergence of tuberculosis (TB) in the early 1880s, causing the death of many reserve populations (Daschuk, 2013; Logan McCallum, 2017; Wildcat, 2015). Though TB had been largely reintroduced among Indigenous communities by European settlers during the fur trade era dating back to the 1670s, infected individuals were often asymptomatic due to previous bison consumption providing high nutrition levels (Daschuk, 2013; Logan McCallum, 2017; Wildcat, 2015). Other diseases like measles, smallpox, and scarlet fever began to break out across nations, all further exacerbated by malnutrition (Daschuk, 2013; Logan McCallum, 2017; Wildcat, 2015). Indigenous peoples began protesting the ill-treatment from the government, who were disregarding their responsibility to protect Indigenous peoples from famine, in accordance with 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). Despite the adoption of this clause, government officials failed to provide assistance to First Nations and as such, disease and sickness continued to spread within communities (Daschuk, 2013). The rights entrenched in treaties started to become "a series of broken promises" (Hamilton and Sinclair, 1991).

In the late 1800s, Indigenous peoples continued to be heavily burdened by TB. The first tuberculosis sanitorium in Canada was created in Gravenhurst, Ontario in 1897, as a means of containing TB spread (Ontario Ministry of Public and Business Service Delivery, 2012). Indigenous peoples were forcibly removed from their communities and sent to sanitoria (often far from home) to receive TB treatment (Lux, 2010). During the same period, Cree and Nokado Oyadebi infants in Saskatchewan were subjected to trials for experimental bacille Calmette-Guérin vaccine for TB (Lux, 2016).

Under the guise of further containing the spread of TB, Indian hospitals were created in the 1930s (Lux, 2010). However, the true purpose of Indian hospitals was to create segregation and contain the perceived threat Indigenous peoples imposed on the non-Indigenous population (Drees, 2010; Lux 2010). Enforced hospitalization and physical restraint was common among patients, and health care practitioners in these settings were often undertrained and unlicensed (Drees, 2010). There are several other instances of medical mistreatment and abuse towards Indigenous peoples that remain undocumented. These harmful experiences have caused intergenerational trauma for Indigenous peoples and perpetuate further distrust of governments and the health care system.

Contemporary Health Care Experiences

Today, Indigenous peoples continue to experience discrimination, racism, and structural violence from the health care system (Browne et al., 2016; Kitching et al., 2018; Wylie & McConkey, 2019). Much of the ongoing discrimination stems from the negative stereotypes perpetuated about Indigenous peoples, including assumptions about alcohol and drug abuse, unemployment, and limited education (Kitching et al., 2018; NCCIH, 2014). The lack of commitment from provincial and federal governments to invest in affordable housing, mental health supports, and improvements to health service access and delivery perpetuates structural racism (NCCIH, 2014). Unfortunately, the structure and organization of health care in Canada continues to reflect colonial attitudes and practices, resulting in another layer of obstacles for Indigenous peoples seeking health care (Vukic et al., 2012).

Indigenous Peoples in Alberta

Alberta has experienced a large rate of growth in recent years, with the population sitting at an estimated 4.6 million as of December 2022 (Government of Alberta, 2023). The most populated regions lie between the Edmonton-Calgary corridor, which only makes up 6% of the land in Alberta but hosts 76% of the population (Government of Alberta, 2023). Home to the third largest number of Indigenous peoples per capita, Alberta has a total Indigenous population of 6.5%, which is broken down as 53% First Nations, 44% Métis, and 1% Inuit (ISC, 2022). Each of First Nations, Inuit, and Métis populations comprise many nations with distinct traditions, cultures, and ceremonial practices. As of 2016, 51.8% of Indigenous peoples in Alberta live in urban contexts (Alberta Health Services [AHS], 2020).

First Nations

First Nations comprise both status (registered as Indian under *The Indian Act*) and non-status (identified as First Nations, but not registered under *The Indian Act*) individuals (AHS, 2020a). In Alberta, there are 45 First Nations communities and 140 reserves, spanning across Treaties 6, 7, and 8, shown in Figure 1 (ISC, 2022). Each treaty area is supported by a specific Treaty organization: Confederacy of Treaty 6, Treaty 7 Management Corporation (governed by the Blackfoot Confederacy as of 2017), and Treaty 8 First Nations of Alberta (AHS, 2020a).

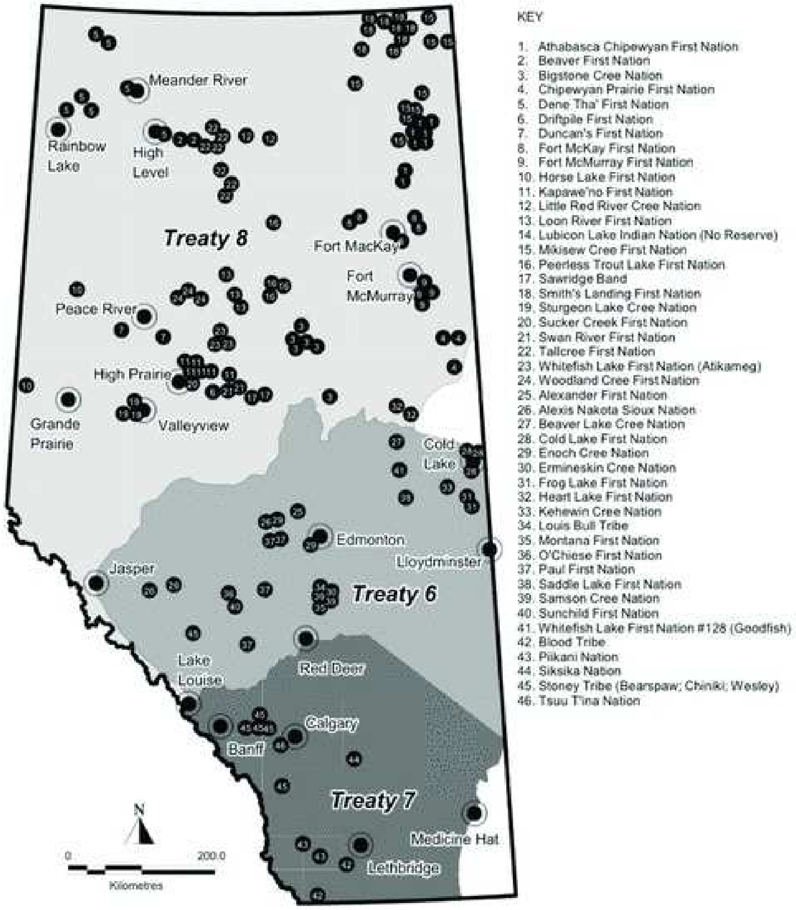


Figure 1. Map of First Nations Treaty areas and communities in Alberta. Available online from: https://northernspiritrc.ca/about-us/indigenous-ministries/.

Métis

Métis have mixed Indigenous and European ancestry and have been considered intermediaries between cultures (ISC, 2022). While over 80% of Métis people in Canada reside in Ontario, Alberta has the largest Métis population across the western provinces (ISC, 2022). Since 1928, the Métis Nation of Alberta has governed Métis in the province (ISC, 2022; Métis Nation of Alberta, 2022). Alberta is the only province where Métis have rights over specific land areas, known as Métis settlements (ISC, 2022). There are eight Métis settlements across the province, shown in Figure 2. There are approximately 5,632 residents on Métis settlements as of 2018 (ISC, 2022).

Figure 2. Map of Métis Settlement regions in Alberta. Available online from: https://empoweringthespirit.ca/wp-content/uploads/2017/05/Métis-in-Alberta-Part-2-Governance-and-Settlements-.pdf.

Inuit

The majority of Inuit in Canada live across Inuit Nunangat, which is comprised of Nunavut, Nunavik (Northern Quebec), Nunatsiavut (Northern Newfoundland and Labrador), and the Inuvialuit Settlement Region (Northwest Territories) (AHS, 2020a; ISC, 2022). As such, there are only around 2,500 Inuit living in Alberta, with a large proportion residing in Edmonton (AHS, 2020a).

Primary Health Care (PHC)

Definition of PHC

The Alma Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, which proposes primary health care (PHC) as a means to increase health care access and reduce health inequalities (World Health Organization, 1978). According to the Alma Ata Declaration, PHC is described as “essential health care services based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families […] through their full participation […] in the spirit of self-reliance and self-determination” (World Health Organization, 1978, p. 1) With a broad definition, PHC sits at the intersection of clinical and social care and recognizes the influence of the social determinants of health (e.g., education, housing, social inclusion) on health equity (World Health Organization, 1978).

A strengthened PHC system has been recognized as one of the most essential pathways to reduce health disparities and to garner efforts towards health system improvement (Hutchinson et al., 2011; Spooner et al., 2021; van Weel, 2018), with an emphasis on shifting services towards inter-disciplinary team-based models of care (Henderson et al., 2018). Furthermore, PHC can work to promote health equity by addressing historical injustices that drive health care disparities through political and resource pathways (Browne et al., 2016). As such, PHC is well-positioned to address the inequities that undermine the health and wellness of a population (Hutchinson et al., 2011; Spooner et al., 2021; van Weel, 2018).

PHC Landscape in Canada

PHC in Canada today is embedded in the historical powers, roles, and responsibilities across federal, provincial, and territorial governments under the 1867 *Constitution Act* (Health

Canada, 2019). Publicly funded health care is financed with general revenue raised through federal, provincial, and territorial taxation, such as personal and corporate taxes, sales tax, payroll levies and other revenue (Health Canada, 2019). The federal government's roles in health care include setting and administering national principles for the system under the CHA; financial support to the provinces and territories; and several other functions, including funding and/or delivery of primary and supplementary services to certain population groups (Health Canada, 2019). The responsibility for public health, which includes sanitation, infectious diseases, and related education, is shared between the three orders of government: federal, provincial/territorial, and municipal (Health Canada, 2019). However, these services are generally delivered at the provincial/territorial and municipal levels (Health Canada, 2019).

In Canada, the broader PHC agenda has historically been characterized by a series of false starts, unsustainable pilot projects, and an overarching failure to embrace incremental change (Hutchison et al., 2001; Hutchison et al., 2011). Many factors have contributed to a lack of systemic change, including the pursuit of large-scale reform under unfavourable conditions, the fiscal inability of governments to invest in PHC infrastructure, and disregard for policy legacies and historically embedded social values (Hutchison, 2008). With growing political and public concern about the quality of health care services, there was increased pressure for federal, provincial, and territorial governments to deliver improvements to PHC (Hutchison, 2008). Eventually, in the early 2000s, a policy environment for PHC renewal was established, as policymakers across several provinces (including Alberta) began to appreciate lessons of the past, including how policy legacies can influence change and that a single, best PHC model does not exist (Hutchison, 2008).

PHC Landscape in Alberta

PHC delivery in Alberta involves several governing bodies, including Alberta Health and AHS. Alberta Health is responsible for setting policy and legislation, and allocating health funding (Government of Alberta, 2022). AHS carries out health service planning and delivery to residents of Alberta across more than 900 facilities in the province (AHS, 2023). In 2014, Alberta introduced their *Primary Health Care Strategy* to frame PHC reform in the province (Government of Alberta, 2014). The Strategy describes PHC as the following:

> Primary health care is the first place people go for health care or wellness advice and programs, treatment of a health issue or injury, or to diagnose or manage physical and mental health conditions. In Alberta, primary health care includes a wide range of services delivered by teams of providers that can include physicians, nurses, psychologists, pharmacists, dietitians, counsellors, rehabilitation therapists, and social workers, among others, depending on the needs of the people with whom they are working. Social and community initiatives such as housing, employment, and income supports are part of the programming people can draw on to support their overall health and well-being. (p. 8)

The main model of PHC delivery in Alberta is via Primary Care Networks (PCNs) (Leslie et al., 2020). PCNs were created through a joint venture between Alberta Health, the Alberta Medical Association, and the regional health authorities (which was eventually merged into AHS). The three parties signed an eight year (2003–2011) Trilateral Master Agreement to support Local Primary Care Initiatives (Leslie et al., 2020). PCNs in Alberta are supported by funding for infrastructure, quality improvement, and team-based care. Nearly 84% of family physicians in

Alberta have voluntarily signed a contract with a PCN, with the aim to develop programs and services that reflect local priorities (Leslie et al., 2020).

Indigenous PHC Context in Alberta

PHC for First Nations in Alberta is provided and/or funded by First Nations organizations, Alberta Health Services, Alberta Health, and FNIHB-AB. First Nations have access to the provincial health system including hospital care and specialized services through AHS and physician care funded by Alberta Health. First Nations peoples can also access federally funded health programs and services including the Non-Insured Health Benefits program, which covers prescribed medication, medical supplies and equipment, dental care, vision care, short-term crisis counselling and medical transportation (Health Canada, 2010a). Most First Nations communities are funded by FNIHB-AB to deliver health programs and services including health promotion and disease prevention activities, public health, and limited treatment, essentially home and community care (Health Canada, 2012). FNIHB-AB staff provide direct health services in several First Nations communities; in most cases, it is linked to the provision of nursing services (Health Canada, 2012), but also includes environmental health services and some preventative dental services. To supplement the existing FNIHB-funded basket of services, several communities have established partnerships with AHS and/or local PCNs to offer access to a broader range of health professionals such as nurse practitioners, midwives, and physicians, as well as other programs and services including diagnostic and screening services (Health Canada, 2012).

Several health care collaborations have also been established and implemented at the community, Tribal Council, Treaty, and provincial levels. In 1996, most First Nations Chiefs in Alberta signed a Co-Management Agreement with the federal Minister of Health to support the co-management of the FNIHB-AB funding (Health Co-Management, 1996). As for provincially funded PHC services specifically for Indigenous peoples, there are limited clinical resources for Indigenous-focused PHC. The Elbow River Healing Lodge, the Indigenous Wellness Clinic, and the Indigenous Virtual Care Clinic have emerged from local action and reliance on community partnerships and relationships for resources, but do not reflect provincial strategic initiatives (Crowshoe et al., 2022).

While there are various organizations and government bodies responsible for the delivery of PHC services, the patchwork nature of these services has resulted in under-resourced and ill-equipped PHC delivery for First Nations, Inuit, and Métis in Alberta (Crowshoe et al., 2022). Furthermore, a formal mechanism to connect these PHC programs and services is lacking, which may exacerbate existing health inequities (Crowshoe et al., 2022). Intentional policy shifts within PHC organizational entities and broader legislation can support improved PHC access, quality, and safety for Indigenous peoples in Alberta (Crowshoe et al., 2022).

Conclusion

This chapter provided background on Indigenous peoples in Canada, their historical relationships with the federal government, and their health care experiences. Additionally, the concept of PHC was introduced and the context of PHC delivery in Canada and Alberta was described to situate this policy project. The following chapter describes the policy problem, the research objectives, and describes my positionality in relation to this research.

CHAPTER 2: RESEARCH PURPOSE AND OBJECTIVES

Description of the Policy Problem

PHC transformations are needed to improve health and achieve equity for Indigenous peoples in Canada (Henderson et al., 2018). However, within First Nations, Inuit, Métis, rural and remote contexts, PHC services remain widely inaccessible, chronically under-funded, and disconnected from each other and from mainstream PHC services (Crowshoe et al., 2022; Henderson et al., 2018). The fragmentation observed within Indigenous PHC delivery today has been shaped by historical policy choices that set future path dependency. Continued jurisdictional boundaries disconnect federal and provincial policy makers and have reinforced institutional arrangements shaping the delivery and organization of PHC (Henderson et al., 2018; Lavoie, 2013). This creates barriers for Indigenous peoples in accessing PHC services, both on- and off-reserve. Furthermore, there is a lack of representation of Indigenous peoples in decision-making processes within PHC policy development, which has resulted in policies and programs that fail to address the experiences and unique needs of diverse Indigenous populations (Fridkin et al., 2019). Six years after the release of the 94 Calls to Action by the Truth and Reconciliation Commission of Canada (TRC), there is increasing pressure to close gaps on health inequities for Indigenous peoples (TRC, 2015). PHC transformation within Indigenous contexts should be rooted in policy, guided by Indigenous peoples, and concurrently address the root causes of health disparities, including the impacts of colonialism, assimilation, cultural genocide, oppression, and broken trust (Crowshoe et al., 2019). Health policy analysis in Indigenous PHC in Canada is limited and in-depth case studies examining the health policy-making process are lacking. The purpose of this thesis is to examine how existing health policies have shaped the Indigenous PHC policy landscape over nearly six decades by providing a comprehensive analysis of health policy decisions that have shaped developments in Indigenous PHC delivery in the province of Alberta. By examining these policy shifts within Indigenous PHC, this research aims to contribute to the larger discourse on strengthening Indigenous PHC in both Alberta and Canada and enhance opportunities for Indigenous peoples to be involved in decision-making on health services planning and delivery.

Research Objectives

My thesis research was carried out as a project for the Indigenous Primary Health Care and Policy Research (IPHCPR) network of Alberta (Crowshoe et al., 2021; IPHCPR, n.d.). The IPHCPR's vision is to "promote a renewed and transformed PHC system to achieve Indigenous health equity by advancing research that links knowledge to policy and practice, fomenting evidence-informed structural and policy innovations based in equity and Indigenous ways of knowing," (IPHCPR, n.d.). The network aims to establish a foundation for more in-depth policy research on innovative models for Indigenous PHC delivery across Canada (IPHCPR, n.d.). With the guidance and support of the IPHCHR network, my thesis contributes to a growing evidence base on Indigenous PHC policy in Alberta.

An examination and analysis of past health policy decisions pertaining to PHC can enhance our understanding of decision-making processes, and support policy changes for advancing Indigenous PHC that align with the priorities, values, and needs of Indigenous peoples. Thus, my thesis was guided by the following research objectives:

1. To examine historical and present-day policy shifts or changes that have shaped Indigenous PHC delivery in Alberta; and
2. To examine the historical and current engagement of Indigenous peoples in PHC policy making in Alberta.

Significance of the Research

The previous chapter provided a brief overview of the development of health care for Indigenous peoples and their non-Indigenous counterparts in Canada. The involvement of multiple jurisdictions has been described as "a complex array of federal, provincial, and aboriginal services, and concerns have been raised about the adequacy of coordination among these" (United Nations Human Rights Council, 2014, p. 10). As the health gap between Indigenous and non-Indigenous peoples continues to widen, critical health policy action is warranted to mend the fragmented system (United Nations Human Rights Council, 2014). With this research, I sought to explore the nature and impact of historical policy decisions to elicit valuable insights on the current state of Indigenous PHC and where future efforts should be directed to strengthen the PHC system for Indigenous peoples. Reform within mainstream PHC could better respond to Indigenous peoples' health needs and support Indigenous-led innovations in service delivery rooted in policy. By studying Indigenous PHC policy development in Alberta, I hope to critically examine the objectives of the policies implemented, uncover the policy and decision-making process that led to its development and implementation, and identify outcomes that resulted from the policies and decisions enacted.

Positionality

Critical reflection of one's cultural identity, positioning, and power – otherwise known as *reflexivity* – enables a researcher to understand the kind of knowledge being produced, how the knowledge is produced, and an opportunity to confront personal assumptions and biases (Berger, 2013; Dawson et al., 2022). Engaging in this reflexive process is critical to all phases of the research to gain insights as to how the research continues to shape their experiences and who they are becoming (Samms Hurley & Jackson, 2020). Across Indigenous research methodologies, an emphasis is placed on *positionality*, which is underpinned by the premise that people stand in relation to others (Berger, 2015; Greene, 2014; Wilson, 2014). As such, positionality reflects the *relational* aspect between the researcher and those who engage in the research (Holmes, 2020; Wilson, 2014).

I am a settler woman born, raised, and currently living on unceded and stolen Algonquin Territory, the ancestral land of the Anishinaabe Nation, in what we now call Ottawa, Ontario. My parents are both from Mangalore, a coastal city in the South of India. They immigrated to Canada in the early 1990s, landing in Ottawa. Many of my relatives also immigrated to Canada around this time. As a second-generation settler, I grew up with a flourishing love of languages and cultures. Although I was not brought up in the most multicultural city, my parents encouraged me to experience new cultures and traditions through travel and education.

As one of the few South Asian students in my high school, there were very few opportunities for me to connect with my culture. It was not until I started my undergraduate degree at the University of Ottawa that I began to meet many more students from the South Asian diaspora. This opportunity allowed me to build connections with folks who had similar lived experiences, strengthening my cultural identity. I am privileged to have a strong sense of community and belonging.

In my second year at the University of Ottawa, I was asked to write a policy paper on a pressing public health issue. After doing some background research, I came across an article that described the elevated rates of tuberculosis among Inuit living in Nunavut. I was shocked, as I was completely unaware of this public health crisis and how it was impacting folks so close to home. Prior to this, I had also struggled to understand Indigenous issues more broadly and the reason for increased attention to Indigenous rights in media and within politics. I proceeded to speak with one of my mentors, who was from Yellowknife and had been working in Indigenous health for several years. She encouraged me to re-examine my beliefs about Indigenous peoples and to learn more about their lived experiences as shaped by colonization, residential schools, and ongoing violence. These teachings led me to start accepting my many privileges as a settler and my responsibilities to Indigenous peoples as an ally.

As a non-Indigenous learner, I have had the honour and privilege of being engaged in Indigenous health research for over six years, including projects focused on infectious disease prevention, food insecurity, diabetes management, and mental health. I am grateful to have had the opportunity to continue learning about Indigenous ways of knowing, being, and doing throughout my graduate studies. I was motivated to work in primary health care, as it encompasses comprehensive health services, considers the impacts of broader determinants of health, and is focused on empowering communities to take charge of their health. Policy, more specifically, can be instrumental in mobilizing solutions to pressing public health issues.

I recognize how colonization has caused the erasure of Indigenous cultures, traditions, and languages and has disconnected many Indigenous peoples from their sense of community. As a non-Indigenous researcher, I hold relational accountability to empower Indigenous knowledges, voices, and experiences, and I was committed to centering their perspectives and experiences in this work. As such, it was important to establish trust and meaningful relationships with the researchers, policy actors, and knowledge-holders engaged in this work. I recognize that will never fully understand the lived experiences of Indigenous peoples and I am humbled and grateful to continue learning from Indigenous scholars and knowledge-holders.

Conclusion

In sum, this chapter provided an overview of the policy problem and study rationale. In Chapter 3, I describe the study design and research methods that were used to address my research objectives.

CHAPTER 3: RESEARCH METHODS

Study Design: Case Study Analysis

This thesis presents the findings from a retrospective policy analysis aimed at generating insights about how PHC policies framed for Indigenous peoples were developed, identifying factors influencing policy making for Indigenous PHC, and assessing to what extent Indigenous peoples were engaged in the policy making process. This research employed a qualitative research design using a case study approach to explore policy changes in Indigenous PHC in Alberta over a period of six decades.

Case study research in public policy is a qualitative research method that is used to enhance our understanding of the policy-making process (Gerring, 2007). Policy case studies on Indigenous PHC are an under-explored and under-evaluated area of study. The case study approach allows in-depth, multi-faceted explorations of complex policy issues focused on posing *'how'* and *'why'* questions (Gerring, 2007; Yin, 1999). This research design is particularly useful in exploring the pathways that result from policy initiatives that have been implemented. Case studies can offer additional insights into *what* gaps exist in Indigenous PHC service delivery or *why* policy choices or decisions related to Indigenous PHC were made (Yin, 2009). Furthermore, case study designs embrace components of several research designs and sources, which is of value to health policy and systems research, as this flexibility supports the generation of theoretical insights that can uncover the complex influences and contextual factors behind policy decisions (Exworthy et al., 2011).

Theoretical Approaches and Frameworks for Policy Analysis: Historical Institutionalism and Punctuated Equilibrium Theory

This policy case study of Indigenous PHC policy development in Alberta was guided by two theoretical approaches for understanding the policy-making process: historical institutionalism and punctuated equilibrium theory. *Historical institutionalism* describes the embedded historical processes, legacies, and contingencies that have implications for both formal and informal procedures, norms, and conventions that influence institutions (Ma, 2007; Pierson, 2000). Historical institutionalism highlights the significant role of institutions in shaping policy and influencing outcomes, as political struggles are often mediated by the contexts within which they take place (i.e., by government) (Steinmo et al., 1992).

Central to historical institutionalism is *path dependency*, a phenomenon that explains how past events have influenced present-day conditions and may constrain later events or decisions (Ma, 2007; Pierson, 2000). These path-dependent constraints cause inertia – in other words, the cost of adhering to the status quo declines, whereas the cost of changing a course of action rises – which limits the options available to policymakers (Ma, 2007). The inertia can be further explained by the concept of *increasing returns*, whereby positive feedback from a course of action results in an equilibrium, which in turn is resistant to change (Pierson, 2000).

Within Indigenous contexts in Alberta, historical institutionalism highlights how institutional legacies (e.g., jurisdictional divisions of power over Indigenous peoples' health) can influence and constrain actions by government (e.g., has caused stark jurisdictional divides related to Indigenous PHC delivery, resulting in fragmentation of care). Furthermore, path dependency explains how changing course (e.g., working to resolve jurisdictional divides by empowering Indigenous self-determination) may be perceived as more costly than steering away from the status quo.

Complementary to historical institutionalism is *punctuated equilibrium theory*, which highlights how factors influencing the policy subsystem (e.g., anomalous events, policy communities or coalitions) can create periods of extreme policy stability, followed by those of rapid policy change (True et al., 2007). Key to this theory are two elements in the policy process: issue definition and agenda-setting. The way issues are *defined* depends on governmental and public priorities, which can cause them to either rise or fall on the public *agenda* (True et al., 2007). Furthermore, policies can either be reinforced (which may produce modest changes) or questioned (which may result in major policy reversals) (True et al., 2007).

In Alberta, Indigenous PHC has experienced a long period of policy stability from the early 1960s to late 1980s. This was followed by short periods of rapid change, one example of which is the restructuring of provincial health services in the 1990s (which supported some Indigenous PHC initiatives) (Legislative Assembly of Alberta, 1994) – highlighting punctuated equilibrium theory in action. Both historical institutionalism and punctuated equilibrium theory support a comprehensive understanding of transformations within Indigenous PHC policy in Alberta, and more broadly, across Canada.

Data Collection

To develop a thorough understanding of the case, the case study approach involves the collection of multiple sources of evidence (Yin, 2009). For this thesis, data collection for the retrospective policy analysis on Indigenous PHC in Alberta involved: (1) virtual meetings with policy actors in Alberta to elicit key knowledge on Indigenous PHC policy development in the province and validate policy analysis findings, and (2) a systematic search of policy documents.

Key Policy Actor Meetings

Incremental policy developments within Indigenous PHC are not well documented. As a result, it was determined that the best course of action for data collection would be to first engage key policy actors in Alberta involved in Indigenous PHC policy development. Several policy actors who currently work or have previously worked within Indigenous PHC were identified through the IPHCPR network and the Indigenous Wellness Core at AHS. In February 2022, a group of ten Indigenous and non-Indigenous policy actors from Alberta were sent email invitations to participate in the project and attend a virtual meeting to explore policy shifts and transformations within Indigenous PHC policy in Alberta. The intention behind bringing together a group of policy actors (rather than conducting one-on-one interviews) was to enable the actors to build upon each others' institutional knowledge and evoke memories of specific policy events. My supervisor and I initially approached the Senior Provincial Director of the Indigenous Wellness Core at AHS for guidance on how elicit perspectives from the policy actors, and it was decided the best approach was to utilize an existing scheduled time where senior provincial leaders and managers within the Indigenous Wellness Core meet, as most of the policy actors identified for my project attend this regular meeting.

We convened two 1.5-hour virtual meetings with key policy actors (listed in Appendix A) in March 2022 and January 2023. At the first meeting, three discussion prompts were shared with the group:

1. Can you describe Indigenous PHC policy developments in Alberta? Do you recall the earliest policy development/implementation for advancing Indigenous PHC in the province?

2. What policy shifts or changes in Indigenous PHC occurred over time in Alberta? Were these shifts informed by previous policy developments? Do you recall specific events that influenced policy change or new policy developments?

3. Are you aware of Indigenous peoples (knowledge-holders, leaders) being engaged in the policy developments you have noted? If so, in what ways were they engaged?

During the March 2022 virtual meeting, policy actors identified several policy events that have shaped Indigenous PHC in Alberta and shared critical contextual information about these events, as well as specific policy sources that were recommended to be included in the policy analysis. Furthermore, actors shared insights on historical and present-day relationships between Indigenous peoples and federal and provincial governments. Many policy actors shared policy documents and resources via email following the meeting. Email communications were used for follow-up questions and to elicit further insights on specific policy documents. Through the conversation and resources shared, a policy timeline of events was developed to inform a search strategy for additional policy sources pertaining to the identified developments. The policy timeline also helped to inform the story on policy shifts and transformations related to Indigenous PHC in Alberta presented in Chapter 4.

The second virtual meeting in January 2023 was convened with the same group of policy actors. This meeting served as an opportunity to bring the findings from the policy analysis back to the expert group, discuss whether the results aligned with knowledge that was shared at the March 2022 meeting, and to share any gaps in understanding or missing policy events in the timeline. Discussions at the meeting elicited new information about additional policy sources and refinement of key themes that emerged from the policy analysis.

Systematic Policy Document Search

A targeted policy document search was conducted through Google search engine under the advice of the policy actors and in accordance with the policy events identified during the March 2022 virtual meeting. Search criteria was amended for each document sought for retrieval. To gather supporting documents and resources related to the policy events identified in the timeline, an additional general search was conducted through Google search engine (using the Advanced Search function) for the following keywords: "Indigenous", "primary health care", "policy", "Alberta", and relevant synonyms. The following criteria was used for the search: (1) Published between 1960-2022; (2) Published in English; (3) Focus on Indigenous PHC policy in Alberta, and/or focus on PHC reform in Alberta.

Some of the key documents shared by policy actors were digitally inaccessible. Policy documents that were not digitally accessible were retrieved in hard-copy format through Dr. Josée Lavoie at the University of Manitoba. Dr. Lavoie is a professor of community health sciences at the University of Manitoba, Canada, and an expert scholar on Indigenous health services and policy research. Through this process, we uncovered several policy documents pertaining to a single policy event.

Policy Sources Retrieved

This retrospective policy analysis was aimed at generating insights about how PHC-focused policies framed for Indigenous peoples were developed and to identify factors influencing policy-making. A document-based, in-depth content analysis was conducted for 37 federal and Alberta (provincial and local) policy sources from 1962-2020, including formal policies, legislation, policy or program evaluations, statements, memorandums of understanding, briefing notes, recommendations, and strategies. Federal policies included were focused on historical arrangements for Indigenous health care in Canada. These policy documents were suggested by the policy actors to be included because they articulated where the policy story needed to begin. Provincial (Alberta) policy documents included were primarily focused on Indigenous PHC development. A table summarizing the key policy documents reviewed is shown in Appendix B.

Frameworks for Data Extraction and Analysis

To support a comprehensive understanding of this policy story, two frameworks were used to extract key information and support data analysis of the included policies in this case study: The Policy Triangle Framework and the Ripples Framework for Meaningful Involvement.

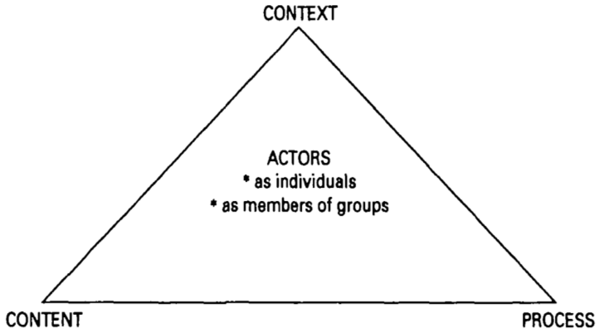


Figure 3. The Policy Triangle Framework - A Model for Health Policy Analysis (Walt & Gilson, 1994).

Figure 4. Ripples Framework for Meaningful Involvement (Fridkin et al., 2019).

Developed by Walt & Gilson (1994), the Policy Triangle Framework was created to specifically support analysis of health policies. Descriptive in nature, this framework was used to explore the interrelationship and interaction among four main components of policy making (shown in Figure 1) which include: actors (individuals, groups, organizations), processes (policy formulation and implementation), context (social, cultural, political, economic), and content (i.e., policy objectives and guidelines) (Walt & Gilson 1994). Although critical in understanding key factors that influence decision-making, the Policy Triangle Framework does not speak to the process of engaging key actors in policy development; gaps which were addressed by employing the Ripples Framework for Meaningful Involvement to explore how Indigenous peoples can be meaningfully engaged in health policy and decision-making (Fridkin et al., 2019). The Ripples Framework was created following 20 in-depth interviews with Indigenous and non-Indigenous decision-makers working in Indigenous health policy in Canada and reflects the research evidence on Indigenous peoples' engagement in health policy (Fridkin et al., 2019). Figure 2 depicts a conceptual model of the Ripples Framework. The ripples (elements) radiating outwards gradually represent more influential approaches for meaningful involvement with Indigenous peoples, which can work to transform and decolonize health policy decision-making processes (Fridkin et al., 2019). Table 1 provides more in-depth descriptions of each element in the Ripples Framework. Both the Policy Triangle Framework and Ripples Framework for Meaningful Involvement guided data analysis and enabled a deeper exploration into the key elements of the policies reviewed.

Table 1. Key Elements of the RIPPLES Framework for Meaningful Involvement

Key Elements of Meaningful Involvement	Summary of Element
Recognizing and Representing Indigenous peoples	Recognizing or acknowledging Indigenous peoples and/or territories and taking efforts to have Indigenous peoples represented at decision-making tables, even if tokenism seems like a false start and not a head start.
Interrupting and Re-Imagining Relationships	Actively interrupting the ways Indigenous peoples and governments have historically worked together and re-defining working relationships based on a process of reconciliation.
Preparing Agreements	Establishing formal, written agreements between parties that articulate the nature of working relationships, mandate Indigenous involvement in the process, commit both parties to sharing responsibility for addressing Indigenous health issues, and hold parties jointly accountable for the decisions made in the process.
Practicing Protocols	Developing and implementing rules for Indigenous peoples' engagement in the process, as well as protocols to guide how the parties will work together and enact the relationships set out in formal agreements.
Leveraging Power	Taking efforts to foster a process that has the necessary power and sufficient capacity to make and implement health policy decisions, such as engaging the highest-level decision-makers in the process.
Exerting Community Authority	Taking explicit efforts to foster a process that is being driven by Indigenous community members, namely, Indigenous individuals who are most connected to and familiar with the issues being addressed and who solely represent a community perspective.
Shifting Social Structures	Taking efforts towards addressing the systemic barriers impeding Indigenous peoples' involvement in policy, such as explicit efforts to incorporate Indigenous paradigms and include, support, and protect Indigenous individuals in high-level positions in the mainstream policy system.

Data Analysis

The meetings with the policy actors were audio-recorded and transcribed verbatim. A document-based, content analysis of policy documents was conducted, and key information was extracted in accordance with the factors outlined in the Policy Triangle Framework and the Ripples Framework for Meaningful Involvement. Following data extraction, the key policy events were organized thematically. Data analysis comprised an iterative approach, as new insights were shared across the two meetings conducted with the policy actors. By adopting an iterative approach, the themes and policy timeline were interpreted and refined through the lens of the policy actors.

Methodological Limitations

There are a few methodological limitations to the case study design. Firstly, as the case study research design comprises several research approaches and methods, there is space for flexibility and subjectivity. The aim behind incorporating several research approaches and paradigms is that they can work harmoniously to support ongoing learning throughout the research process and help contribute towards a strengthened research agenda for Indigenous PHC policy. Secondly, as described earlier, the policy analysis findings are contextually specific to Indigenous populations in Alberta, thereby limiting generalizability; however, some of the findings may resonate with other Indigenous peoples' experiences and support policy learnings for Indigenous PHC beyond Alberta. Another limitation to this study is researcher bias, which stems from an investigator's preconceived expectations or beliefs that lead to unintended errors in the research process (Chenail, 2011). To address this, I placed emphasis on unpacking my positionality to better understand the relational accountability I hold to empower Indigenous voices and experiences throughout this research. Furthermore, I focused on my reflexivity throughout the thesis, which is the examination of one's own beliefs and judgements during the research process (Wilson, 2014). Although this study presents some methodological limitations, many can be addressed by honouring the concepts of flexibility, adaptability and positionality, and reflexivity. Other limitations are related to the policy expert meetings as a form of data collection. Participants may have poor recall when sharing details of past events or experiences (Yin, 2009). While poor recall cannot be remedied, thoughtful probing questions as outlined above lead to insightful dialogue during policy expert discussions with all participants.

Ethics

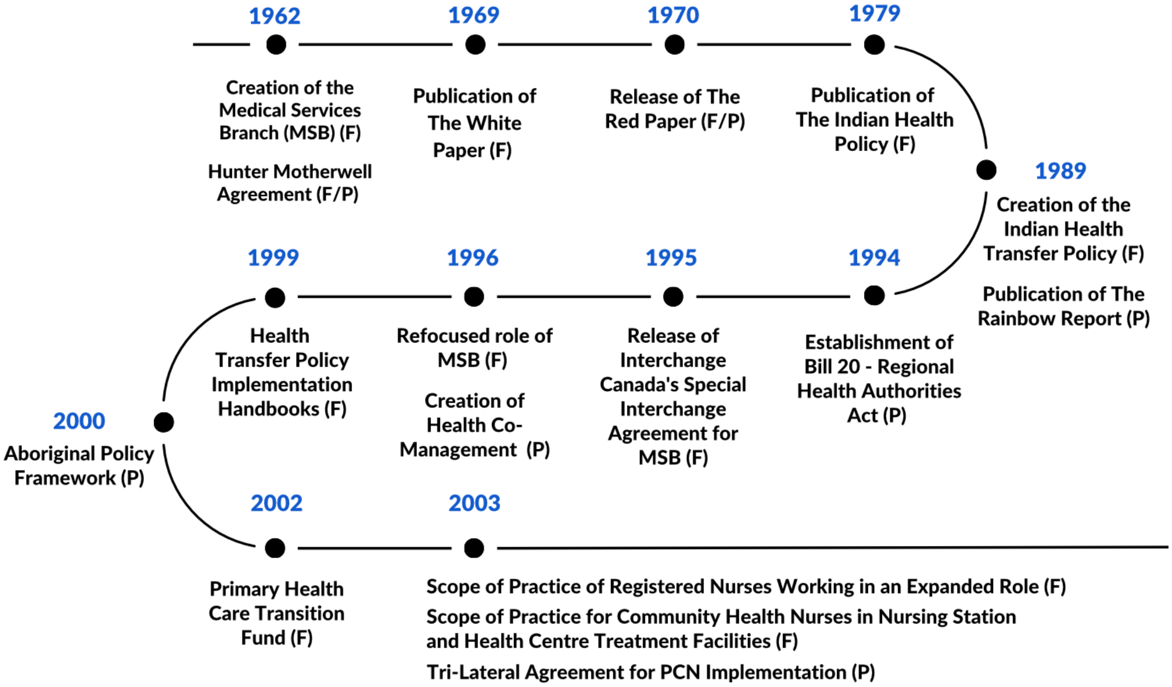
As a sub study of a Canadian Institutes for Health Research (CIHR) Network Environments for Indigenous Health Research (NEIHR) grant, this study was approved by the University of Alberta Research Ethics Board # Pro00103372. All policy actors provided verbal consent to participate in the meetings and this was audio recorded at the start of the meeting.

Conclusion

This chapter described the case study research design, theoretical approaches, the two sources of data collection, and the frameworks used for data extraction and analysis. Furthermore, methodological limitations of this research were explored. The following chapter will provide a descriptive content analysis of the policy findings.

CHAPTER 4: POLICY ANALYSIS FINDINGS

A timeline of seminal policy events at both the federal and provincial levels was developed following the meeting with policy actors in March 2022. The additional documents retrieved through the expert scholar at the University of Manitoba addressed many residual knowledge gaps and further contextualized key historical policy shifts. The complete policy timeline of policy documents analyzed is shown in Figure 5. Additionally, a summary table of the policy analysis findings in relation to the Policy Triangle Framework and RIPPLES Framework for Meaningful Involvement can be found in Appendix C. Each policy event highlighted in the timeline supports a more coherent story of Indigenous PHC policy development and shifts in Alberta. Key policy events were organized under four distinct categories: (1) Framing Government Responsibilities on Health Care Delivery for Indigenous Peoples; (2) Framing of Indigenous Peoples Rights to Health; (3) Enhancing Collaboration for Indigenous PHC; and (4) Indigenous PHC-focused reforms.



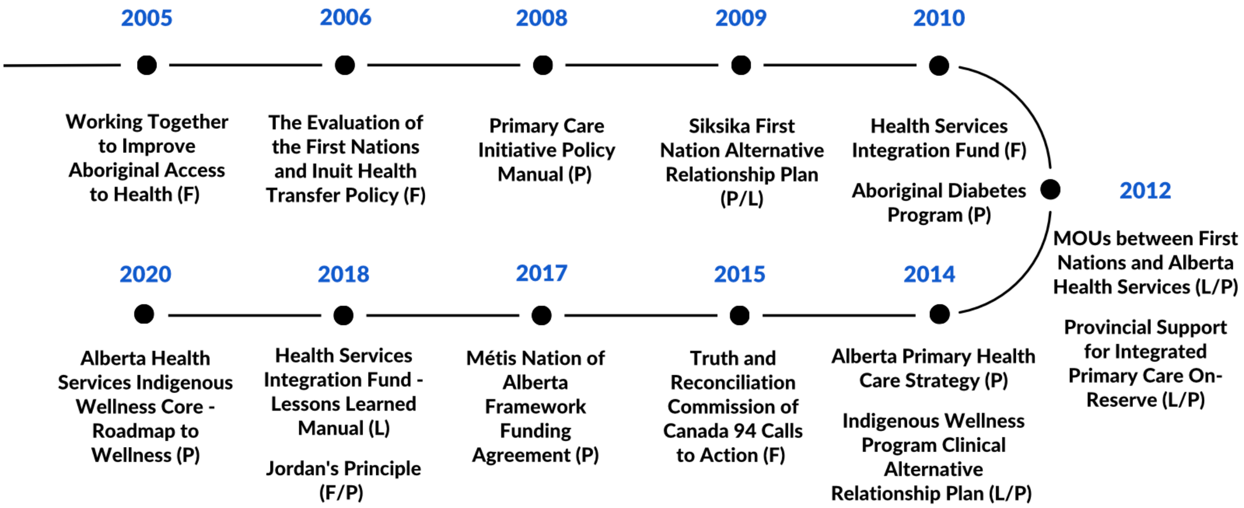


Figure 5. Timeline of Indigenous PHC in Alberta. F indicates a federal policy, P indicates a provincial (Alberta) policy, and L indicates a local policy within Alberta.

Framing Government Responsibilities on Health Care Delivery for Indigenous Peoples

The Federal Role for Indigenous Health Care

Health care delivery for Indigenous peoples has historically been framed around the federal government's constitutional role in the administration of health care services to First Nations on-reserve and Inuit communities, as outlined under Section 91(24) of the British North America Act (1867), leaving other Indigenous groups (Métis, First Nations off-reserve), under the purview of provincial and territorial governments. As the TB crisis was brought under control, it became apparent that there was an urgent need for health services in Indigenous communities. The Department of Indian Affairs at the time set up a Medical Branch in 1927 (March 2022 Meeting with Policy Actors). In late 1936, the Department of Mines and Resources replaced the Department of Indian Affairs and assumed responsibility for Indians, including what had become the *Indian Health Services Division* (March 2022 Meeting with Policy Actors). Initially situated within the federal Department of Indian Affairs (est. 1880), management of health services for First Nations and Inuit peoples was transferred to the Department of Health and Welfare upon its creation in 1945 (March 2022 Meeting with Policy Actors). This federal department went on to establish a Medical Services Branch (MSB) in 1962 (presently the First Nations and Inuit Health Branch (FNIHB)), mandated to provide health care services that fell out of provincial jurisdiction to First Nations (MSB, 1988). With the creation of the MSB, the federal government increased its involvement in health care for First Nations and Inuit in Canada. Initially centered on public health priorities, services were intended to expand to include PHC, dental care, mental health, environmental health, home and continuing care, and non-insured health benefits (MSB, 1988). Thus, the establishment of the MSB 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). Outlined in the agreement was 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). This agreement included the following terms (Rogers, 1968, p. 3):

(1) Non-Indians on Indian Reserves will be given assistance by the Indian Affairs Branch, when required, in the same manner and form as non-Indians in similar circumstances; and

(2) Indians of Indian Reserves will be given assistance by the Provincial Welfare Branch, when required, in the same manner and form as non-Indians in similar circumstances.

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). As stated in the National Social Assistance Review document: “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, p. 2). As such, the Agreement was altered to imply 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. While this policy was not specific to PHC, it was suggested by one of the policy actors to include in the analysis as it represented a historical example of the controversy between the federal and provincial governments on the responsibility of urban First Nations and the debate between which government should finance the services and who should delivery those services (both for on and off-reserve).

The publication of *The White Paper* (formally known as the Statement of the Government of Canada on Indian Policy) in 1969 was an indication of the government of the day’s intention to get out of the business of Indigenous health care altogether (Government of Canada, 1969; March 2022 Meeting with Policy Actors). In *The White Paper*, the federal government stipulated “that services come through the same channels and from the same government agencies for all Canadians” (Government of Canada, 1969, p. 7) and shared the government’s plan to eliminate Indian status by dismantling the 1876 Indian Act (Government of Canada, 1969). The overarching goal of *The White Paper* was to pressure Indians to assimilate into *Canadian culture*, and become recognized as citizens with the same rights, opportunities, and responsibilities as non-Indians (Government of Canada, 1969). Moreover, *The White Paper* signalled the federal government's intent to pass its responsibilities for First Nations health services to the provincial governments. As a result, this policy paper provides a critical foundation to this policy story, as the propositions made (if enacted) would have completely dismantled previously established Indigenous-focused health programs and services (March 2022 Meeting with Policy Actors).

The White Paper was met with strong opposition from First Nations communities across the country, igniting a new wave of Indigenous advocacy (March 2022 Meeting with Policy Actors). In response to *The White Paper*, First Nations leaders developed *The Red Paper* (formally known as Citizens Plus) in 1970, a counter-narrative emphasizing the unique rights and identities of First Nations and the need for reform (Indian Chiefs of Alberta, 1970). Leading its development was Mr. Harold Cardinal, a Cree leader from the Indian Association of Alberta, who met with the Liberal Cabinet to present *The Red Paper* (March 2022 Meeting with Policy Actors). This paper argued strongly against assimilation and contested that Indian people had signed the historical treaties with the Crown as equals, that the treaties were sacred and promises made in the treaties were everlasting. *The White Paper* became heavily criticized by many, leading to its ultimate retraction by the federal government the following year (March 2022 Meeting with Policy Actors).

Transfer of Health Services and the Residual Role of the MSB

Despite First Nations voicing their concerns over the federal government's ongoing responsibilities, the government attempted to reduce their role in health care service delivery to only serve indigent First Nations in 1978 (Lavoie, 2018). This was met with opposition from the National Indian Brotherhood (now the Assembly of First Nations), a reaction which sparked the release of the *Indian Health Policy* in 1979 (Lavoie, 2018; March 2022 Meeting with Policy Actors). The federal government outlined the basis for its involvement in the delivery of health services for First Nations and Inuit in this two-page policy document (Health Canada, 2007a). Furthermore, it committed to improving First Nations and Inuit health by focusing on three pillars (Health Canada, 2007a):

- Community development which highlights the importance of involving First Nations peoples in addressing health issues.
- Traditional relationship between First Nations peoples and the federal government which outlines the need for an ongoing role for the federal government and seeks to encourage better communications and greater involvement of First Nations peoples in the development and implementation of health care.
- Interrelated Canadian health system where the federal government commits to maintain its involvement, encouraged the provinces to play their role in filling the gaps in the "diagnostic and treatment of acute and chronic diseases and in the rehabilitation of the sick" (Health Canada, 2007a, p. 1) and encouraged greater involvement of First Nations peoples in the decision-making process.

The *Indian Health Policy* document did not stipulate plans for how the three pillars for action would be implemented (Health Canada, 2007a). Ten years later in 1989, the *Indian Health Transfer Policy*, 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 the MSB to support the intended goals of the *Indian Health Policy* (Treasury Board of Canada, 1989). Created alongside a subcommittee of First Nations health workers, the *Indian Health Transfer Policy* provided an opportunity for First Nations to have increased control over health care delivery by promoting community responsibility over health services (Treasury Board of Canada, 1989). Only First Nations and Inuit Peoples situated south of the 60th parallel were eligible to undergo health transfer, once again excluding Métis and northern-situated Indigenous populations (Treasury Board of Canada, 1989). The *Indian Health Transfer Policy* was supported with substantial funding, bolstering $7.76 million from 1989-1990 and $17.25 million from 1992-1993, to support community health transfer initiatives (Health Canada, 1999).

Interchange Canada's *Special Interchange Arrangement* was established by the Public Service Commission and the Treasury Board in 1988 to support the transfer of heath programs under the MSB (Interchange Canada, 1995). At the same time, the Public Service Commission was threatening a national nursing strike if primary care nurses supported health transfer (January 2023 Meeting with Policy Actors). This agreement was implemented as a way for First Nations to include dental therapists and community primary care nurses working in an expanded role as part of their community health team. The guidelines outlined by the *Special Interchange Agreement* stipulated that because "the functions performed by dental therapists and nurses working in an expanded role are not recognized under some provincial health regulations, employees performing these functions cannot be hired directly by First Nations." (Interchange Canada, 1995, p. 2). The exception to this was that in Alberta and British Columbia, primary care nurses and dental therapists could be hired directly by First Nations communities (Interchange Canada, 1995). The MSB assumed responsibility for training and supervision of dental therapist and nurses (Interchange Canada, 1995). Nurses working for the federal government have assumed responsibilities under an extended scope of practice in PHC that can include performance of diagnostic, prescription of a limited number of drugs such as antibiotics, doing sutures, and in some regions, x-ray of limbs (Lavoie et al., 2006). This agreement expanded community control over PHC services for First Nations by enabling direct hire of health professionals.

Later, in 1999, Health Canada released three compendium handbooks to the *Indian Health Transfer Policy*, highlighting three different levels of community control: (1) Health Transfer, (2) Integrated, and (3) Non-transferred/Non-integrated (Health Canada, 1999). Health 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 have less control as they share responsibility for health service delivery with FNIHB (Health Canada, 1999). The Non-transferred/Non-Integrated level has no dedicated resources for administration within their agreements (Lavoie et al., 2006). One example of transfer described by policy actors as a "success story" was the transfer of the Non-Insured Health Benefits program to Bigstone Cree First Nation, a semi-isolated community in northern Alberta (March 2022 Meeting with Policy Actors). In 1996, Bigstone Cree Nation chose to take transferred responsibility of medical transportations and later, took responsibility of all goods and services under the Non-Insured Health Benefits program (March 2022 Meeting with Policy Actors).

Through commitments to implement the 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 to all First Nations communities, defining the residual role of the Branch. The report shared that residual roles were required for accountability (e.g., medical, financial, managerial, and administrative expertise; capital planning and management; delivery of non-transferred programs) and professional expertise (e.g., personnel assistance and advice)

(MSB, 1996). While the document highlights the MSB's responsibilities to provide certain health services and health-related developmental assistance to First Nations communities, the defined areas of support are limited to those described above (MSB, 1996). Findings from a short-term evaluation of health transfer in 1992 noted that extensive discussions with First Nations were held across the country to understand their interpretation of the MSB's residual role (MSB, 1996). While many First Nations communities desired self-determination over health, they did not see the removal of the MSB from their fiduciary responsibilities on First Nation and Inuit health (MSB, 1996). Following this, MSB took primary care out of nations in 2002, which further demonstrates their ambivalent contributions to support Indigenous PHC (March 2022 Meeting with Policy Actors). However, the MSB made some exceptions to their PHC decisions (March 2022 Meeting with Policy Actors). For instance, after the community hospital was closed down, MSB continued to offer primary care to Siksika First Nation as a compromise for the hospital closure (March 2022 Meeting with Policy Actors).

Framing of Indigenous Peoples Rights to Health

Indigenous Participation in Health Care Decision-Making

As the *Indian Health Transfer Policy* was undergoing implementation, 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 (National Library of Canada, 1989). The Rainbow Report did not outline specific actions or plans related to Indigenous health care or PHC delivery; however, it was included in the policy analysis because it signaled attention to a lack of commitment to

Indigenous peoples' right to health (National Library of Canada, 1989). As shown with previous policy decisions related to health care delivery for First Nations and Inuit in Canada, the federal government has adopted the position that the provision of health care to Indigenous peoples is a matter of policy, not of Indigenous rights. As such, it is unsurprising that *The Rainbow Report* failed to offer supports for Indigenous PHC in its reform plans (National Library of Canada, 1989)

The report's recommendations were later used as the foundation for implementing a decentralized model of health care delivery in Alberta (similar to other provinces), which entailed a transfer of authority from the Department of Health to regional health authorities (Leslie, 2020). In Alberta, this involved 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* (Legislative Assembly of Alberta, 1994). Decentralization was intended to increase opportunities for public participation by tasking each health region with setting local priorities (March 2022 Meeting with Policy Actors). In effect, regionalization added another level of complexity in the complement of services accessible to all Alberta residents, including Indigenous communities (March 2022 Meeting with Policy Actors). Furthermore, the relationship between Indigenous nations in Alberta and the newly minted health regions were not characterized and as such, these relationships were unclear.

Bilateral and Multilateral Health Care Collaborations

In 1996, most First Nations Chiefs in Alberta signed an agreement with the federal Minister of Health that support the co-management, co-assessment, and co-analysis of the FNIHB-AB funding (Health Co-Management, 1996). The agreement is unique to Alberta, allowing First Nations organizations and governments and FNIHB to co-manage the funding for

FNIHB-AB region and reallocate funding efficiencies towards health programs in Treaty 6, 7, & 8 (Health Co-Management, 1996). A Health Co-Management Committee was established comprised of a Health Co-Management Secretariat and several sub-committees on children and youth, operations and support, health protection, mental health and addictions, non-insured health benefits, and prevention programs. The *Health Co-Management Agreement* (1996) marked a move towards greater participation and control for First Nations living on-reserve in the management and decision-making of health services. The policy decisions regarding Transfer and Co-Management carry the potential for significant and substantive progress towards health and well-being of Alberta First Nation communities; however, its success hinges on genuine partnerships.

The *Health Co-Management Agreement* is not the sole health partnership in Alberta between First Nations and the federal government, although it was highlighted by policy actors at the virtual meetings as one of the better-known collaborative agreements (March 2022 Meeting with Policy Actors). In the *Memorandum of Understanding on the Scope of Practices of Registered Nurses Working in an Expanded Role* (2003), it outlined a bilateral agreement between FNIHB and the provinces to bring consistency to requirements for scope of practice of nurses that was deemed favourable by both FNIHB regions and provincial regulatory bodies (FNIHB, 2003). The Memorandum of Understanding describes that FNIHB nurses were expected to comply with the FNIHB scope of practice, which are outlined in the *FNIHB Scope of Practice for Community Health Nurses in Nursing Station and Health Centre Treatment Facilities* document, and to also practice in accordance with the standards of practice of the respective province's regulatory authority (FNIHB, 2003). Nurses working for FNIHB were expected to be registered in the province in which they practice and FNIHB had the authority to prescribe the scope of practice for the nurses it employs (FNIHB, 2003). Registration by nurses in their respective province of practice was later enforced following recommendations outlined in *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report* released in 2005 (Lavoie et al., 2005). The Memorandum of Understanding further states, that in practice situations where the expectations of FNIHB and the provincial regulatory authority differ, the FNIHB scope prevails (FNIHB, 2003).

Responding to Socio-Economic Disparities among Indigenous Peoples

In 2000, *Strengthening Relationships: The Government of Alberta's Aboriginal Policy Framework* was released by the Government of Alberta, outlining the provincial governments' commitment to establish a relationship with First Nation, Métis, and other Aboriginal peoples in the province to address social-economic disparities between Aboriginal and non-Aboriginal communities. Each governmental department was asked to identify what they were doing to address Aboriginal issues within their department, including Alberta Health (March 2022 Meeting with Policy Actors). Although not focused on the provision of health services, the framework's two stated goals were situated within broader understandings of social and economic wellbeing: (1) to increase socio-economic opportunities for Aboriginal peoples; and (2) to further define the roles and responsibilities of federal, provincial, and Aboriginal governments (Government of Alberta, 2000). Multiple meetings were held with First Nation chiefs, Tribal Councils, and Métis settlements, with input from written submissions used to develop the framework. A total of 17 commitments to action were made in the published document and a stipulation to conduct a comprehensive evaluation of the policy framework from 2007-2008; however, the document does not provide details on the nature of the evaluation (e.g., key metrics or indicators of interest) (Government of Alberta, 2000). A search for the proposed evaluation yielded no results, and as such, the long-term outcomes and impact of the *Aboriginal Policy Framework* are unclear. This also appears to be the first policy document in Alberta that acknowledges a commitment to working with Métis and other Indigenous groups, other than First Nations (Government of Alberta, 2000).

Enhancing Collaborations for Indigenous PHC

Alberta underwent several health system reforms, each playing a critical role in advancing Indigenous PHC specifically. 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* to develop new PHC programs and services (Health Canada, 2007b). Alberta was granted nearly $55 million, which was used to develop Health Link Alberta and the Capacity Building Fund (to implement primary care models) between 2002-2006 (Health Canada, 2005). An interim report released in 2005 found that Health Link received over 800,000 calls in its first year of operation, thereby improving access to health services (Health Canada, 2005).

A separate funding envelope of the *Primary Health Care Transition Fund* was designated towards Aboriginal PHC initiatives, which funded one project in Alberta with the Bigstone Cree Nation to address three main priorities 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 (Health Canada, 2007c). Additionally, as a federally funded project, the community had the resources to use performance data to track trends based on indicators of physician, emergency, and hospital visits in northern communities, which helped inform community leaders in deciding where to redirect funds to sustain programming (Health Canada, 2007c). While these federal investments in the early 2000s supported PHC transformation projects in some First Nation communities in Alberta, the province was simultaneously undergoing wide-scale PHC system reforms with a limited focus on Indigenous peoples' health.

Drawing inspiration from the *Primary Health Care Transition Fund*, Alberta saw the creation of the PCNs in 2003, which are presently the most common model of team-based PHC delivery (Leslie et al. 2020; Montesanti et al., 2022). An eight-year Trilateral Master Agreement (2003-2011) was signed between the Alberta Medical Association, the Ministry of Health, and AHS to develop the PCNs (Alberta Medical Association, 2004). The first PCN was launched in 2005, with a total of 41 PCNs across the provinces today (Leslie et al. 2020). 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 Ministry of Health on a fee-for-service basis and have full responsibility over resource allocation (March 2022 Meeting with Policy Actors). To supplement the existing FNIHB-funded basket of services, a number of First Nation communities have established partnerships with AHS and/or local PCNs to offer access to a broader range of health professionals such as nurse practitioners, midwives, and physicians, as well as other programs and services including diagnostic and screening services (Health Canada, 2012; March 2022 Meeting with Policy Actors). The 2008 *Primary Care Initiative Policy Manual* was jointly developed to monitor the implementation and evaluation of PCNs (Government of Alberta, 2018). While PCNs have successfully piloted several local projects, they continue to face challenges with accountability and quality control (Government of Alberta, 2018).

PCN Zone Committees were established to develop zone-wide service plans to align PCN services with population health needs; however, these zone committees did not adopt a population health approach (March 2022 Meeting with Policy Actors). Additionally, a service plan for Indigenous population health needs was not established, highlighting gaps in addressing the specific health needs of Indigenous peoples in Alberta (March 2022 Meeting with Policy Actors). Furthermore, in a 2016 PCN review, feedback shared from physicians indicated a need to update the fee-for-service compensation model to a community or activity-funding model, which would allow for increased community-based program development, including Indigenous communities (Alberta Health, 2016). Today, PCNs provide minimal resources to some on-reserve First Nation communities (March 2022 Meeting with Policy Actors).

Recognizing a need to better support Indigenous peoples' health, the *Aboriginal Health Transition Fund* was released in 2005. The policy document titled *Working Together to Improve Aboriginal Access to Health* states that the Aboriginal Health Transition Fund aimed to develop long-term partnerships to improve health service integration and Indigenous health outcomes (Health Canada, 2010b). A total of 34 projects were funded in Alberta from 2005-2011, all of which prioritized community partnerships (Health Canada, 2010b). For instance, by establishing an inter-jurisdictional deliberation process, AHS extended mobile cancer screening services to communities in the Western Cree Tribal Council (Health Canada, 2010b).

Building on the success of the *Aboriginal Health Transition Fund*, the federal government launched the Health Services Integration Fund in 2010, investing over $80 million for five-year First Nations health innovation projects (ISC, 2020). Between 2012 and 2016, four *Health Services Integration Fund* projects sought approaches to enhance collaboration and improve coordination of health services for First Nations in Alberta. The Operations and Support Sub-Committee of Co-Management was involved in the review and planning for allocating these funds (Health Service Integration Fund Primary Care Project Management Team, 2016).

With access to significant funding to improve PHC delivery and a dedicated workforce, representatives from various 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 alongside 12 First Nations communities 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 the Health Services Integration Fund showcased how relational work with communities can enhance First Nations health overall (Health Service Integration Fund Primary Care Project Management Team, 2016). However, a *Lessons Learned Manual* that was developed highlights several barriers to implementation, including challenges with partnership development, timely communication, and jurisdictional issues (Health Service Integration Fund Primary Care Project Management Team, 2016). While funding these PHC projects was critical to supporting First Nations health, funding was provided to communities with the capacity and resources to sustain such projects. Moreover, recipients for the *Health Services Integration Fund* only included First Nations communities, tribal councils, and organizations, which meant that Inuit and Métis were ineligible to receive this funding (ISC, 2020). Evidently, 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.

An evaluation of the *Health Services Integration Fund* was conducted by Health Canada for project activities that took place between 2012-2016 (Health Canada, 2016). A key finding from this evaluation was an ongoing need for the Health Services Integration Fund program, because of prevailing challenges that First Nations encounter in accessing health services. This resulted in the *Health Services Integration Fund* being renewed between 2018-2021 and again in

2021 (ISC, 2020). Furthermore, this funding has now expanded to include projects that better meet the health needs of Inuit, by enabling Inuit communities and land claim organizations to submit proposals for this funding (ISC, 2022).

Meanwhile, the *Alberta Primary Health Care Strategy* was released in 2014 at a pivotal time where leadership changed at the provincial level (Government of Alberta, 2014). While it envisioned PHC reform in the province, this strategy had no specific provisions for Indigenous PHC. Of relevance to this review was the strategy's strategic directions 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). It is key to note that a strategy is a plan of action designed to achieve an overall aim, and typically includes an evaluation component to track performance and outcome measures (Government of Alberta, 2014). While the *Alberta Primary Health Care Strategy* outlined an aim to complete performance evaluations of programs and services to enable continuous quality improvement, it appears as though there has been little movement in this area, resulting in a lack of clarity as to how this strategy may have contributed towards improved PHC service delivery in the province.

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 MSB worked with Indigenous representatives to start developing the National Aboriginal Diabetes Strategy in 1997 (Public Health Agency of Canada, 2005). Recognizing diabetes as a national health concern, the federal government later created the Canadian Diabetes Strategy in 1999, supported with $115 million of funding (Public Health Agency of Canada, 2005). A key component to the Canadian Diabetes Strategy was the Aboriginal Diabetes Initiative*,* which was developed alongside Indigenous peoples and established in 1999. The Initiative received a total of $523 million in funding over three project phases between 1999-2015 (Public Health Agency of Canada, 2005; Health Canada, 2011).

The Aboriginal Diabetes Initiative established a First Nations and Inuit health region in Alberta, affording Indigenous communities and organizations the opportunity to submit proposals to fund community-based programming (Leung, 2016). Among programs funded through the Aboriginal Diabetes Initiative was the Indigenous (formerly Aboriginal) Diabetes Wellness Program in Edmonton, which provides holistic diabetes care to First Nations (status and non-status), Métis, and Inuit patients and families (Crowshoe et al., 2021). This program was delivered through a Clinical Alternative Relationship Plan model, enabling physician renumeration through the provision of defined primary care services rather than through a fee-for-service 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 (March 2022 Meeting with Policy Actors). The IWPCARP pays physicians to provide PHC services 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 (March 2022 Meeting with Policy Actors). Today, the IWPCARP provides health care services to about half of the 45 First Nation communities in Alberta (March 2022 Meeting with Policy Actors). Moreover, the IWPCARP shifts how physicians are paid, which influences delivery of care. Physicians are employed on a sessional basis, meaning they provide time-based services and are paid on an hourly basis. On average, this does not exceed two days of service per week (March 2022 Meeting with Policy Actors). The *Provincial Support for Integrated Primary Care On-Reserve* (2012) report states that the fee-for-service framework under which most physicians operate has a patient 'volume' focus, whereas an Alternative Relationship Plan may reduce pressure to see more patients, which could be ideal to supporting the health complexities and needs of First Nations (Whiteduck Consulting Ltd., 2012). Currently, the IWPCARP supports 24 full-time equivalent physicians, with AHS responsible for recruitment and retention of physicians (March 2022 Meeting with Policy Actors).

Predating the IWPCARP is the *Siksika Alternative Relationship Plan*, established in 2009 and extended through to 2023. This Alternative Relationship Plan was developed to address several challenges, including barriers to physician recruitment and retention (March 2022 Meeting with Policy Actors). Furthermore, as alluded to previously, deviating away from the fee-for-service model enables physicians to better support their patients' care complexities by easing time constraints (March 2022 Meeting with Policy Actors). Communities were not directly involved in any of the negotiations surrounding the Alternative Relationship Plan development and thus, were not signatories on the agreement (March 2022 Meeting with Policy Actors).

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

Federal Statements on Reconciliation

Several key events led to increased interest in the relationship between First Nations, federal, provincial, and territorial governments. The first of these events was the release of the summary of the final report of the TRC on May 31, 2015 (TRC, 2015). The TRC identified 94 Calls to Action; seven of them are identified as related to the health field. The first of these seven Calls to Action (Call to Action number 18) calls upon: Federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health care rights of Aboriginal people as identified in international law and constitutional law, and under the Treaties (TRC, 2015, p. 207). The other health priority areas identified by the TRC included the need to: measure and close the gaps in health outcomes; address jurisdictional concerns as they relate to individuals not residing on-reserve, Métis and Inuit peoples; fund Aboriginal healing centres; recognize Aboriginal healing practices; increase the number of Aboriginal health-care providers; and, require cultural competency training for students in medical and nursing schools (TRC, 2015).

The second event pertained to Jordan’s Principle in addressing the needs of First Nations children. Jordan River Anderson, a young boy from Norway House Cree Nation in Manitoba, was born with multiple disabilities (Indigenous Services Canada, 2023b). As a result, he was required to stay at the hospital from birth. When doctors gave Jordan’s family the opportunity to move him to special home care, frictions began to rise between the federal and provincial government over responsibilities for his home care (Indigenous Services Canada, 2023b). With the governments never coming to a consensus, Jordan tragically passed away at age 5 without ever leaving the hospital on 2 February 2005. Jordan's Principle was established through the incessant demands of Indigenous people to ensure First Nations children have sufficient publicly funded health, social and education programs, as well as support services (Indigenous Services Canada, 2023b; March 2022 Meeting with Policy Actors).

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). This Memorandum of Understanding allows all signatory parties to address gaps and share information ensuring that children and families in Alberta are receiving necessary supports, including mental health, medical equipment, speech therapy, and educational supports (Government of Alberta, 2018). 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 (March 2022 Meeting with Policy Actors). Sadly, the federal government continues to fight efforts to expand Jordan's Principle to include non-status First Nations, demonstrating a national failure to protect the rights of Indigenous children and families (March 2022 Meeting with Policy Actors).

A Renewed Focus on Relationships

As described in the introductory chapter, the formal recognition of Métis as “Indian” under the Constitution Act only occurred in 2016, which has deprived Métis of their political, cultural, and health rights for several years – some of which can begin to be addressed through ongoing commitments and partnerships (Indigenous Peoples Atlas of Canada, 2018). In 2017, the Métis Nation of Alberta and the Government of Alberta signed a 10-year *Framework Agreement*, to provide a process for both parties to develop respectful relationships and work together to address the needs and preserve the cultural heritage of Métis in the province (Métis Nation of Alberta, 2017). Furthermore, the agreement outlines priority actions including the strengthening of relationships between governing bodies, the provision of operational funding to the Métis Nation of Alberta and working towards legislative recognition of the Association (Métis Nation of Alberta, 2017). For instance, there is an existing Métis health board that the Métis Nation of Alberta envisions to be formally recognized by government, which would promote Métis health priorities at the provincial level (Métis Nation of Alberta, 2017). By enacting the priority actions enlisted in this agreement, the denial of rights that Métis have experienced historically can begin to be addressed. A progress evaluation for the *Framework Agreement* is scheduled for 2024.

As the main provider of health care services in Alberta, AHS further supports Indigenous health priorities through the work of the Indigenous Wellness Core, a team guided by the *Indigenous Health Commitments: Roadmap to Wellness* (AHS, 2020b). This roadmap describes the structures, processes, and organizational changes needed to achieve health equity for Indigenous peoples (AHS, 2020b). The IWC has conducted several listening days with key experts to discuss how the team can best address gaps in Indigenous PHC, which guided the creation of the Roadmap to Wellness document (March 2022 Meeting with Policy Actors). Internally as a unit, AHS grounds their Indigenous health-focused discussions in the TRC Calls to Action and the United Nations Declaration on the Rights of Indigenous People (March 2022 Meeting with Policy Actors), which is a promising step towards embracing reconciliation with Indigenous peoples. While Alberta has missed a provincial opportunity to affirm Indigenous rights by legislating the United Nations Declaration on the Rights of Indigenous People like British Columbia (Crowshoe et al., 2020), it is hopeful to see the IWC embed these policies in their practices.

Conclusion

This chapter described the policy analysis findings, categorized under four broad themes: (1) Framing Government Responsibilities on Health Care Delivery for Indigenous Peoples; (2) Framing of Indigenous Peoples Rights to Health; (3) Enhancing Collaboration for Indigenous PHC; and (4) Indigenous PHC-focused reforms. The following chapter will describe the implications of the research findings for policy and practice, as well as recommendations for future research.

CHAPTER 5: DISCUSSION OF KEY FINDINGS AND BROADER IMPLICATIONS

This retrospective policy analysis case study includes an analysis of federal and provincial policy sources between 1962-2020 to better understand how historical policy decisions on Indigenous health care in Canada have shaped PHC policy developments for Indigenous peoples in the province of Alberta. The findings of the policy analysis explored the interaction among four main components of policy-making guided by the Policy Triangle Framework, which includes actors (individuals, groups, and organizations involved, and their interactions with one another), processes (how policies are formulated and implemented), context (socio-political, cultural, economic, and health system setting), and content (the policy's substance and details such as objectives, operational guidelines, and implementation plans) for each of the included policy documents. Additionally, the Ripples Framework guided interpretation of the degree to which Indigenous peoples have been engaged in each respective health policy development, and what is needed to ensure increased participation of Indigenous peoples in decision-making. By using a framework driven content review and data extraction process for the policy documents, I was able to piece together a comprehensive story that strengthens our understanding of the broader Indigenous PHC policy landscape in Alberta.

Overview of Main Findings from Included Indigenous PHC Policies

As described in Chapter 4, the four categories that encompass the policy findings are as follows: (1) Framing Government Responsibilities on Health Care Delivery for Indigenous Peoples; (2) Framing of Indigenous Peoples Rights to Health; (3) Enhancing Collaboration for Indigenous PHC; and (4) Indigenous PHC-focused reforms. In this chapter, I will discuss the various themes that emerged from each of these categories and situate the findings in relation to other work in this area.

Framing Government Responsibilities on Health Care Delivery for Indigenous Peoples

Historically, health care delivery for Indigenous peoples in Canada has been defined by ongoing shifts in the political agenda of federal and provincial governments in administering health care. The earliest policy documents included in this review demonstrate the federal government's intentions to either divert or altogether abandon their responsibilities for Indigenous peoples' health by: (1) transferring responsibilities from federal to provincial government (e.g., release of *The White Paper*) or (2) altering terms of an agreement to limit fiduciary duties (e.g., changes in financial responsibility following the signing of the *Hunter-Motherwell Agreement*). Furthermore, with the release of *The White Paper,* the government announced their intention to pressure Indians to assimilate to *Canadian culture*, practices which are rooted in the country's colonial history. As the province deviated from their financial obligations under the *Hunter-Motherwell Agreement*, it mirrored how the federal government did not provide assistance to support disease control in Indigenous communities during a period of widespread famine in the 18970s, although it was their responsibility under the Medicine Chest Clause. Therefore, the federal government's actions not only indicate their desire to get out of the business of Indigenous health care, but their avoidance in accepting Indigenous peoples as peoples with rich cultures, histories, and identities unique from non-Indigenous people.

Several years later, the release of the *Indian Health Policy* and the *Indian Health Transfer Policy* envisioned commitment from the federal government to strengthen relationships with First Nations and Inuit, and to facilitate community responsibility over health service delivery through the introduction of health transfer agreements and greater integration into provincial systems. However, there are several issues to highlight with each of these national policies. The brief *Indian Health Policy* document neglected to include plans for the implementation of its three core pillars, the most important of which is community development. Mashford-Pringle and Webb (2023) appraised the 1979 policy, citing “The Indian Health Policy did not state how community development was to be achieved, nor indicate any evaluation or measurement tools to monitor progress,” (2023, p. 67). Similar reflections were described with respects to the other two pillars of the *Indian Health Policy* (Mashford-Pringle & Webb, 2023).

The *Indian Health Transfer Policy* has been cited as the “only tangible outcome” of the *Indian Health Policy’s* implementation (Lavoie, 2013; Mashford-Pringle & Webb, 2023). The summative evaluation report on the *Indian Health Transfer Policy* titled *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report* was released in 2005 (Lavoie et al., 2005). The evaluation found that health transfer led to improvements in health care access and overall health outcomes (Lavoie et al., 2005). However, it also described 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, provinces, and FNIHB (Lavoie et al., 2005). As such, while both the *Indian Health Policy* and *Indian Health Transfer Policy* showed promise, there is a lack of translation between the stated *aims* (content) of a policy vs. how the policy *was implemented* (process), a theme which is highlighted across several of the policy documents included in this study. Although policies set out to achieve specific goals and objectives, there are several factors that can impede on their progress, resulting in suboptimal outcomes.

Framing of Indigenous Peoples Rights to Health

The 1990s marked a pivotal time for an increase of Indigenous engagement and participation in decision-making in Alberta. However, the release of *The Rainbow Report* (1990), while positioned more broadly on health care reform in Alberta, made no provisions for

Indigenous PHC. As this report described broader opportunities to increase community participation, it was unfortunate that there was no movement to specifically increase Indigenous community participation in health care reform.

The establishment of the *Health Co-Management Agreement* (1996) is a noteworthy example of engagement as it promotes collaboration between First Nations and FNIHB to strengthen health program and service delivery for First Nations and reinforces supports for increased community responsibility over health care delivery. As the bilateral agreement is presently effective, this structure supports continuous engagement between First Nations and government, and highlights FNIHB's ongoing commitment to the wellbeing of First Nations in the province. By the end of the 1990s, there was a promising trend in Alberta's commitment to capacity-building for Indigenous peoples.

Enhancing Collaborations for Indigenous PHC

In the early 2000s, increased attention for PHC development was matched with increased interest in moving the needle forward to support Indigenous health. The release of the Primary Health Care Transition Fund, Aboriginal Health Transition Fund, and Health Service Integration Fund initiatives signalled the federal government's financial commitment to developing high-quality PHC services and advancing Indigenous health through the implementation of community health innovation projects. Although these large-scale funding opportunities helped boost health system transformation, they were time-limited, which impacts long-term sustainability from the program's outcomes. However, a fortunate aspect of some of these larger-scale projects is significant resourcing available for program evaluation. As described by Vaughan et al. (1984), the purpose of evaluations, especially for health policies and programs, is to "make good management decisions," (1984, p. 1). For example, the *Primary Health Care*

Transition Fund pilot project in Bigstone Cree Nation had sufficient resources to track performance data, which helped community leaders decide how funds could be redirected to sustain programming. Similarly, with Health Service Integration Fund, an evaluation conducted by Health Canada revealed a dire need for the community health innovation projects. This evaluation established precedence for the renewal of the Health Service Integration Fund, which has occurred twice to date (2018-2021; 2021-onwards). As such, an evaluation is necessary for program sustainability.

Meanwhile, the creation of the PCNs and release of the *Alberta Primary Health Care Strategy* steered away from the federal efforts to improve Indigenous health, with no Indigenous PHC-specific provisions included in either of these policy documents. Both of these policy decisions draw parallels to a *top-down approach*, whereby a policy decision is implemented by an authoritative decision-maker (e.g., senior policy officials) (Watson, 2014). A lack of clear objectives and continuous monitoring can result in an implementation failure (Watson, 2014). In the case of the PCNs, the governing bodies who established the agreement were the Alberta Medical Association, Ministry of Health, and AHS (i.e., authoritative decision-makers). On the other hand, First Nations later established partnerships with local PCNs to offer a broader range of health programs and services, which can be described by the *bottom-up model*, where experience on the frontlines supports the formulation of policy responses (Watson, 2014). Since an Indigenous-specific PCN does not exist, First Nations in Alberta have to work around the existing policy to better support their health needs.

Indigenous PHC-Focused Reform

For decades, Indigenous peoples have been vocal about their rights to self-government and self-determination, in hopes of enacting their inherent rights prior to European settlement.

While Indigenous self-government has been possible for some nations, the complexities that stem from the pre-existing relationship between Indigenous peoples and government institutions can be challenging to navigate, and as such, paths to self-governance require lengthy negotiation processes between both parties (Crown-Indigenous Relations and Northern Affairs Canada, 2020). Therefore, it is critical that institutions make concerted efforts to *decolonize* the policy making process, to transform the existing *power imbalance* that settlers and their governments have over Indigenous peoples and lands (Indigenous Climate Action, n.d.). One way for government institutions to foster welcoming policy spaces is by establishing trusting relationships with Indigenous peoples, especially when the desire stems from communities themselves (Eni et al., 2021). One example is the Memorandum of Understanding signed between some First Nations communities and AHS, an initiative that was driven by local efforts. Another example of a policy created in collaboration between Indigenous and provincial governments is the 2017 *Framework Agreement* between the Métis Nation of Alberta and the Government of Alberta. As Métis were only formally recognized under The Constitution Act in 2016, establishing partnerships with government may help accelerate advancing priority actions for their communities.

At the federal level, possibilities for renewed relationships between Indigenous peoples and federal and provincial governments were emerging. The release of the TRC's 94 Calls to Action indicated the government's pledge to fully acknowledge the cultural genocide caused by colonization, assimilation, and residential schooling, and to create systems and policies that support Indigenous people's healing. However, nearly eight years after the TRC's release, only 13/94 of the Calls to Action have been completed (Yellowhead Institute, 2022). In the *Calls to Action Accountability: A 2022 Status Update on Reconciliation* published by the Yellowhead

Institute (2022), Dr. Janet Smylie shares that if the federal governments want to achieve the health Calls to Action, they need to ensure that "Indigenous communities – whether they are on reserves or major urban centres like Toronto – have the resources and decision-making powers they need," (2022, p. 28).

Implications and Recommendations for Policy and Practice

A Request to Address Jurisdictional Complexities

Many research articles have highlighted the ongoing jurisdictional challenges surrounding roles and responsibilities of various systems and governments that pose challenges to Indigenous PHC delivery (Lavoie, 2013; Mashford-Pringle & Webb, 2023). Indigenous peoples are required to navigate a patchwork of health care services when accessing care, as services are (unequally) divided between the provinces/territories, FNIHB, and ISC, resulting in ongoing jurisdictional misalignment between the federal and provincial governments. It has been long argued that a mechanism is needed to bridge these jurisdictional gaps to help improve the coordination and delivery of PHC services for Indigenous peoples (Crowshoe et al., 2022; Lavoie, 2013). This could include clarification by governments of their roles and responsibilities in PHC delivery; employment of Indigenous health policy frameworks to establish cross-jurisdictional mechanisms to address existing gaps; and/or an explicit commitment to achieving health equity for all Indigenous peoples. Regardless of the approach, continuous engagement and empowerment of Indigenous voices is key to addressing the complex nature of existing PHC fragmentation. To quote former Assembly of First Nations Chief Phil Fontaine, "the answers lie in our communities," (Privy Council Office, 2019).

A Call for Further Policy Evaluations

Through this policy analysis, it became worryingly evident that the impact of many of these policy reforms remains unclear due to the scarcity of comprehensive evaluations in this area. A lack of evaluation of previous policy decisions can hinder knowledge translation of evidence into practice, which can misguide future policy directions. For instance, my research has highlighted that PHC policies most beneficial to communities are those that have emerged from local action and have been specifically created to address Indigenous health priorities, such as the IWPCARP. 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.

Moreover, large-scale, federal initiatives supported by significant funding have the resources to conduct thorough evaluations (e.g., the *Indian Health Transfer Policy*, the Primary Health Care Transition Fund), compared to smaller-scale, local initiatives where capacity may be limited. For instance, while the Health Service Integration Fund enabled the creation of community driven PHC projects, the *Lessons Learned Manual* (an output of evaluation) highlighted barriers around funding limitations and inconsistencies, as well as jurisdictional complexities – learnings which can support future directions for community policy and programs. Sufficient resources should be provided to evaluation to highlight gaps in policy and inform future directions. Furthermore, Indigenous peoples should be engaged in policy evaluations, to understand which metrics are of importance and which benchmarks would be indicative of a policy implementation success to them.

A Demand for Increased Indigenous Engagement

To mobilize government institutions to achieve Indigenous health equity, there needs to be Indigenous engagement in the conception, implementation, and evaluation of PHC policies, programs, and services. As described earlier, Indigenous health is not a core mandate of the PCNs, with Zone governance only recently establishing positions for Indigenous leaders at each Zone decision-making table. One recommendation proposed by scholars is to establish an Indigenous PCN, which would enable Indigenous PHC transformation in the province by supporting the creation of Indigenous PHC infrastructure, addressing the comprehensive health needs of Indigenous populations directly, and dedicating space for community advocacy (Crowshoe et al., 2022).

Another mechanism to increase Indigenous engagement in PHC decision-making is through the creation of an Alberta Indigenous Primary Health Care Board (Crowshoe et al., 2022). Proposed by Crowshoe et al. (2022), the board would function as a supportive and inclusive Indigenous-led governance structure to improve the health and wellbeing of Indigenous peoples in Alberta. As a status neutral entity, the Board would include Indigenous leaders across the province and serve as an accountability structure to address PHC service gaps, reform delivery, and address jurisdictional ambiguity (Crowshoe et al., 2022). Furthermore, the Board could leverage both provincial and federal governments to support Indigenous PHC service infrastructure in Alberta by strengthening their financial commitments and responsibilities (Crowshoe et al., 2022). Thus, establishing an Alberta Indigenous Primary Health Care Board has strong potential to strengthen Indigenous representation in policy and support broader PHC transformation.

Although several policy initiatives have been implemented in Alberta, Indigenous PHC continues to be chronically under-resourced and under-funded. Unfortunately, changes to governmental leadership can jeopardize the limited funding and resources available to communities. A protective factor to this threat is to embed Indigenous representation at all relevant decision-making tables, which could act as a mechanism to ensure Indigenous health needs remain a priority in ways Indigenous peoples would like to see actualized. Increasing the uptake of Indigenous-led PHC models would further promote sustainability of PHC policies and programs for Indigenous peoples.

Future Directions

The findings from this policy analysis can inform current policy reform initiatives in Alberta. Earlier this year, Health Minister Jason Copping launched the Modernizing Alberta's Primary Health Care System (MAPS) initiative to identify practical improvements to increase access to PHC for all Albertans, and to increase Indigenous-led primary health care delivery, over the next five to ten years. To help accomplish this, an Indigenous Advisory Panel of First Nations and Métis experts with extensive experience in delivering community based PHC was appointed to recommend opportunities to improve PHC for Indigenous peoples. A particular issue on the government's agenda is the implementation of innovative models of Indigenous-led PHC that might address the barriers to PHC access in the province. The approach to engagement that the Government of Alberta is taking with this reform initiative is a great example of meaningful Indigenous engagement – something we have not seen in previous policy decisions.

More broadly, the federal government is currently working on co-developing a distinctions-based Indigenous health legislation, at the root of which is *Joyce's Principle* – created to ensure the safety and well-being of Indigenous peoples (ISC, 2023c). While the intended goal of this legislation was to adopt a co-design approach with Indigenous peoples, ISC came out with guidelines for the legislation, rather than starting with true co-design by asking Indigenous peoples what they wanted to see in a health legislation (January 2023 Meeting with Policy Actors). The government has proposed a multi-step targeted process to engagement, beginning with nations and regional Indigenous organizations and later spanning to national groups (ISC, 2023c). Through the guidance of the Elders Advisory Circle, ISC held a one-day virtual event to discuss the creation of this legislation on 22 February 2022 (ISC, 2023c). Suggestions to the content of the legislation were to adopt a whole-of-person health approach as defined by Indigenous peoples, to support Indigenous-led models, to ensure federal accountability, and to address systemic discrimination and racism within health care (ISC, 2023c). As ambiguity and jurisdictional divides have strained relationships between Indigenous peoples and government, a rights-based, Indigenous-driven health legislation is a promising step towards embracing reconciliation.

Study Strengths and Limitations

To my knowledge, this thesis is the first to offer a comprehensive overview and analysis of historical and current-day Indigenous PHC policies in Alberta, Canada. These findings add valuable information to a growing body of literature on Indigenous PHC experiences and Indigenous engagement in the development and implementation of PHC policies. A key strength to this study is the engagement of Alberta policy actors who have been directly involved in decision-making, planning, or implementation of the policy developments. Within Indigenous

PHC policy, there is considerable information that remains undocumented or publicly inaccessible, and as such, the engagement of policy actors can be useful in uncovering policy stories and in contextualizing the events surrounding a policy decision. Additionally, the inclusion of informal policy documents in this review served to strengthen our policy story. While most policy analyses include only formal policy documents (e.g., legislation, strategies), informal policy documents (e.g., briefing notes, memos, action plans, roadmaps, and lesson manuals) provide critical context to policy decisions.

Despite these strengths, there are a few limitations to this policy study. As described in the methods chapter of this thesis, some methodological limitations to this study include a lack of generalizability of study findings, potential researcher bias, and poor recall during the meetings with policy actors. Further limitations were experienced when attempting to access policy documents. In some cases, a policy actor shared their knowledge of a policy event but was unable to share the relevant policy document because it was either: (1) a restricted document, (2) digitally inaccessible, (3) they were unable to locate the document. To tell a comprehensive policy story, policy events are described even in the absence of original policy documents, using insights from policy actors who filled in gaps by sharing their institutional memory of the policy event or specific policy documents (e.g., notes, correspondences) of relevance to the policy decision. A further point to poor recall, with a retrospective analysis including policy events that span back six decades, it can be very difficult to recollect institutional memories and details surrounding past policy decisions. During the January 2023 meeting, some policy actors were even able to recall memories and share new information that would have otherwise been unknown to me.

Another limitation to this research is that many of the policies reviewed were targeted towards First Nations on and off-reserve, which indicates a severe sidelining of Métis, Inuit, and non-status Indigenous peoples' health needs. With Métis comprising 43% of the total Indigenous population in Alberta, it is worrying to witness the large gaps that exist within Métis PHC. It was unsurprising to discover that there are very few PHC-specific policies with stipulations for Métis, which is largely due to the jurisdictional limbo Métis have experienced for decades. The exclusion of Métis in historic policies has led to their absence in some present-day reforms, a right to which Métis continue to advocate for relentlessly. Recognizing the diversity of cultures, traditions, languages, and knowledges between First Nations, Inuit, and Métis, distinctions based PHC policies that service the unique needs of each Indigenous group will improve their health care experiences and advance health equity.

Conclusion

This research has explored Indigenous PHC policy shifts and changes in Alberta over six decades to better understand the existing landscape of Indigenous PHC policies, assess Indigenous engagement in policy-making processes, and to provide considerations for future PHC policy and decision-making. Several policies to improve Indigenous peoples' health experience exist in Alberta, the best of which have emerged from local action. Despite all these efforts, Indigenous peoples seeking PHC still fall through the cracks because of the impacts of colonization, racism, discrimination, perpetual deliberations over responsibilities for their health care, inaccessible health services, as well as inadequate funding, infrastructure, and resources for PHC. While more recent, Indigenous PHC policy reforms have seen some success, future reforms should ensure that Indigenous peoples are at the helm of the decision-making to enrich the Indigenous PHC landscape and pathways to Indigenous health equity.

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Appendix A: List of key policy actors

Name	**Affiliation (Role, Organization)**	**Indigenous or non-Indigenous**
Dr. Richard Musto	Retired, former Calgary Zone Medical Officer of Health, Alberta Health Services	Non-Indigenous
Dr. Esther Tailfeathers	Senior Medical Director, Provincial Indigenous Wellness Core, Alberta Health Services	Indigenous
Dr. Chris Sarin	Senior Medical Officer of Health, Indigenous Services Canada Alberta Region	Non-Indigenous
Ms. Val Austen-Wiebe	Senior Provincial Director, Indigenous Wellness Core, Alberta Health Services	Non-Indigenous
Mr. Marty Landry	Executive Director, Indigenous Wellness Core, Alberta Health Services	Indigenous
Mr. Wayne Labonte	Clinical and Medical Manager, Indigenous Wellness Core, Alberta Health Services	Non-Indigenous
Mr. Kienan Williams	Program Lead, Innovation and Research, Indigenous Wellness Core, Alberta Health Services	Indigenous
Mr. Tyler White	Chief Executive Officer, Siksika Health Services	Indigenous
Ms. Margaret Kargard	Clinical Services Team Lead, Siksika Health Services	Non-Indigenous

Appendix B: List of reviewed policies

Policy Title	Policy Type	Year Enacted/ Implemented/ Published	Publishing Organization	Authoring Organization
Hunter-Motherwell Agreement	Agreement	1962	ISC (Department of Indian Affairs and Northern Development)	GoA, ISC
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 (Indian Health Transfer Policy)	Decision	1989	Treasury Board of Canada	Minister of National Health and Welfare; Treasury Bord of Canada
Rainbow Report	Plan	1989	National Library of Canada	Premier's Commission on Health of Future Albertans
Refocussed 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	Agreement	1996	Health Co-Management	Health Co-Management
Indian Health Policy Transfer Implementation Handbooks 1, 2, and 3	Plan	1999	FNIHB (Department of National Health and Welfare)	FNIHB (Department of National Health and Welfare)
Strengthening Relationships: Government of Alberta's Aboriginal Policy Framework	Framework	2000	Government of Alberta	Government of Alberta
Primary Health Care Transition Fund Initiative	Decision	2002	Government of Canada	Government of Canada

Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements	Agreement	2003	Alberta Medical Association	AHS, Alberta Medical Association, Ministry of Health
Working Together to Improve Aboriginal Access to Health	Decision	2005	Health Canada	Health Canada
Primary Care Initiative Policy Manual	Manual	2008	Government of Alberta	AHS, Alberta Medical Association, Government of Alberta
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
Aboriginal Diabetes Initiative Program Framework	Framework	2011	Health Canada	Health Canada
Health Services Integration Fund	Decision	2011	ISC	ISC
Memorandum of Understanding between Alberta Health Services and Alberta Native Friendship Centres	MOU	2012	AHS	Alberta Native Friendship Centres, AHS
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	Government of Alberta	Alberta Health, Government of Alberta
Indigenous Wellness Program Clinical Alternative Relationship Plan	Ministerial Order	2014	Alberta Health	Alberta Health
Health Services Integration Fund: Lessons Learned Manual	Manual	2016	Health Services Integration Fund Primary Care Project Management Team	Health Services Integration Fund Primary Care Project Management Team
Metis Nation of Alberta Framework Funding Agreement	Agreement	2017	Metis Nation of Alberta	Metis Nation of Alberta
Memorandum of Understanding on Implementation of Jordan's Principle in Alberta	MOU	2018	GoA	First Nations Health Consortium, AHS
Indigenous Health Commitments: Roadmap to Wellness	Roadmap	2020	AHS	AHS

Appendix C: Findings in relation to frameworks for data extraction and analysis

Policy Title	**Policy Triangle: Actors** (individuals, groups, organizations)	**Policy Triangle: Context** (social, cultural, political, economic)	**Policy Triangle: Process** (policy formulation and implementation)	**Policy Triangle: Content** (stated policy objectives and guidelines)	**Ripples Framework for Meaningful Involvement** (1 - Recognizing and Representing Indigenous Peoples; 2 - Interrupting and Re-Imagining Relationships; 3 - Preparing Agreements; 4 - Practicing Protocols; 5 - Leveraging Power; 6 - Exerting Community Authority; and 7 - Shifting Social Structures)
1. Hunter-Motherwell Agreement	Department of Indian Affairs and Northern Health, Government of Alberta	Federal government's early involvement in First Nations and Inuit health care	Communications between actors at the federal and provincial level	To extend funding for social services to First Nations on and off-reserves	Recognizing and Representing Indigenous Peoples
2. Statement of the Government of Canada on Indian Policy (The White Paper)	Government of Canada	Released following consultations with First Nations representatives who expressed concerns over Aboriginal rights; highlights the federal government's intention to get out of the business of Indigenous health care altogether	Details on the policy process are unclear	To eliminate Indian status and pressure Indians to assimilate into *Canadian culture*	N/A – Does not involve Indigenous peoples on any of the seven levels
3. Citizens Plus (The Red Paper)	Indian Chiefs of Alberts	Opposition paper and response to the White Paper by First Nations leaders	Development led by Mr. Harold Cardinal; presented to the Liberal Cabinet	To emphasize the unique rights and identities of First Nations	Exerting Community Authority
4. Indian Health Policy	FNIHB, Health Canada	Released after the National Indian Brotherhood	Details on the policy process are unclear	To express commitment to improving First	Interrupting and Re-Imagining Relationships

		expressed their concerns about the government's responsibilities in health care delivery		Nations and Inuit health through three pillars	
5. Memorandum of Understanding between the Minister of National Health and Welfare and the Treasury Board Concerning the Transfer of Health Services to Indian Control (Indian Health Transfer Policy)	Minister of the Department of Health and Welfare, Treasury Board	Released by the federal government as a positive effort to meet demands for autonomy and control over health services from First Nations	Details on the policy process are unclear	To advance the stated goals of the Indian Health Policy	Preparing Agreements
6. Interchange Canada's Special Interchange Agreement for Medical Services Branch, Health, and Welfare Canada	Health and Welfare Canada	Public Service Commission's attempt to enable First Nations to include dental therapists and community primary care nurses as part of their community health team	Established by the Public Service Commission and the Treasury Board	To support the transfer of health programs under the Medical Services Branch	N/A - Does not involve Indigenous peoples on any of the seven levels
7. Indian Health Policy Transfer Implementation Handbook 1	FNIHB, Health Canada	Details on the context behind the policy are unclear	Details on the policy process are unclear	To provide a comprehensive overview of the levels of community control under the Indian Health Transfer Policy	Practicing Protocols
8. Indian Health Policy Transfer Implementation Handbook 2	FNIHB, Health Canada	Details on the context behind the policy are unclear	Details on the policy process are unclear	To provide a comprehensive overview of the levels of community control under the Indian Health Transfer Policy	Practicing Protocols

9. Indian Health Policy Transfer Implementation Handbook 3	FNIHB, Health Canada	Details on the context behind the policy are unclear	Details on the policy process are unclear	To provide a comprehensive overview of the levels of community control under the Indian Health Transfer Policy	Practicing Protocols
10. Refocussed Role of Medical Services Branch	Health and Welfare Canada	Demonstrates the MSB's continued attempts to limit its role in health care	Details on the policy process are unclear	To define the residual role of the Medical Services Branch for First Nations communities	N/A - Does not involve Indigenous peoples on any of the seven levels
11. Rainbow Report	Premier's Commission on Future Health Care for Albertans	Government of Alberta was focused on health care reform more broadly	Details on the policy process are unclear	To make a case for the regionalization of health services in Alberta	N/A - Does not involve Indigenous peoples on any of the seven levels
12. Regional Health Authorities Act (Bill 20)	Legislative Assembly of Alberta	The basis of this Act came from recommendations highlighted in the Rainbow Report	Passed a legislation consistent with larger fiscal agenda	To support a transfer of authority from the Department of Health to regional health authorities	N/A - Does not involve Indigenous peoples on any of the seven levels
13. Health Co-Management	FNIHB, First Nations Chiefs	Coincides with the federal government's commitment to increase First Nations decision-making in health care	Agreement between First Nations leaders and FNIHB	To support the co-management of FNIHB-AB funding between First Nations organizations and FNIHB	Leveraging Power
14. Memorandum of Understanding on the Scope of Practice of Registered Nurses Working in an Expanded Role	Provincial governments, FNIHB	Highlights federal governments' attempts to develop collaborative agreements	Agreement between FNIHB and the provinces	To bring consistency in requirements for scope of practice of nurses	N/A - Does not involve Indigenous peoples on any of the seven levels

15. FNIHB Scope of Practice for Community Health Nurses in Nursing Station and Health Centre Treatment Facilities	Provincial governments. FNIHB	Highlights federal governments' attempts to develop collaborative agreements	Agreement between FNIHB and the provinces	To highlight nurse requirements to comply with FNIHB scope of practice	N/A - Does not involve Indigenous peoples on any of the seven levels
16. The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report	Dr Josée G. Lavoie, Dr John O'Neil, Lora Sanderson, Dr Brenda Elias, Dr Javier Mignone, Dr Judith Bartlett, Dr Evelyn Forget, Russell Burton, Corry Schmeichel and Della McNeil; Advisory Committee from the Assembly of First Nations	Evaluation requested by the First Nations and Inuit Health Branch to assess the results and impact of the transfer policy objectives and effectiveness of the health transfer continuum of activities	Created by the policy actors identified and presented to FNIHB/Health Canada	To offer a comprehensive evaluation of the First Nations and Inuit Health Transfer Policy	Recognizing and Representing Indigenous Peoples
17. Strengthening Relationships: Government of Alberta's Aboriginal Policy Framework	Government of Alberta	Outlines the provincial government's commitment to establish relationships with First Nations, Métis, and other Indigenous peoples in Alberta	Details on the policy process are unclear	To outline the Government of Alberta's commitment to building relationships and addressing socio-economic disparities for Aboriginal communities	Preparing Agreements
18. Primary Health Care Transition Fund Initiative	First Ministers, Government of Canada	The importance of PHC was expressed in 2000 by the First Ministers health agreements, as a mechanism to accelerate PHC renewal	Funding released by the federal government	To fund new PHC programs and services across the country	Recognizing and Representing Indigenous Peoples

19. Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements (PCN Agreement)	Minister of Health and Wellness, Alberta Medical Association, Regional Health Authorities	Highlight's Alberta's commitment to improve local delivery of health care programs and services	Agreement signed between the Ministry of Health, Alberta Medical Association, and Alberta Health Services	To enable the development of the Primary Care Networks in Alberta	N/A - Does not involve Indigenous peoples on any of the seven levels
20. Primary Care Initiative Policy Manual	Alberta Health Services, Alberta Medical Association, Government of Alberta	Commitment to evaluate PCNs	Details on the policy process are unclear	To monitor the implementation and evaluation of the Primary Care Networks	N/A - Does not involve Indigenous peoples on any of the seven levels
21. Working Together to Improve Aboriginal Access to Health	Government of Canada	Highlights federal commitment to develop long-term partnerships with Indigenous communities	Funding released by the federal government	To fund projects aimed at improving health service integration and Indigenous health outcomes	Preparing Agreements
22. Health Services Integration Fund	Indigenous Services Canada	Highlights federal commitment to develop ongoing relationships with Indigenous communities and improve health service delivery	Funding released by the federal government	To fund First Nations health innovation projects	Leveraging Power
23. Provincial Support for Integrated Primary Care On-Reserve	Kee Tas Kee Now Tribal Council, Siksika Health and Wellness, Western Cree Tribal Council, and Yellowhead Tribal Council	Collaboration between 12 First Nations communities to pilot primary care programs on-reserve	Established by representatives from various groups	To collaborate and pilot primary care programs alongside 12 First Nations communities	Exerting Community Authority
24. Health Services Integration Fund: Lessons Learned Manual	Health Service Integration Fund Primary Care Project	Demonstrates a commitment to evaluate HSIF project	Established by the Health Service Integration Fund Project	To summarize lessons learned following implementation of	Exerting Community Authority

	Management Team		Management Team in Alberta	the *Provincial Support for Integrated Primary Care Programs on-reserve* project	
25. Alberta's Primary Health Care Strategy	Alberta Health	Released when leadership changed at the provincial level	Details on the policy process are unclear	To envision PHC reform in the province	N/A - Does not involve Indigenous peoples on any of the seven levels
26. Aboriginal Diabetes Initiative Program Framework	Health Canada, Government of Canada, Indigenous Representatives	Established due to growing concerns about diabetes management for Indigenous communities	Component of the funded Canadian Diabetes Strategy	To fund reform initiatives for diabetes management	Interrupting and Re-Imagining Relationships
27. Indigenous Wellness Program Clinical Alternative Relationship Plan	Alberta Health, Alberta family physicians	Created following the success of the Indigenous Diabetes Wellness Program (component of the Aboriginal Diabetes Initiative)	Details on the policy process are unclear	To shift how physicians are paid to provide PHC services to First Nation community health centres	Shifting Social Structures
28. Siksika Alternative Relationship Plan	Siksika Nation	Created to address challenges with primary care delivery	Details on the policy process are unclear	To address existing barriers to physician recruitment and retention	Exerting Community Authority
29. Memorandum of Understanding between Alberta Health Services and Tribal Chief Ventures Inc.	Alberta Health Services, Tribal Chief Ventures Inc.	Demonstrates commitments from the provincial government to provide more comprehensive health services for First Nations	Agreement signed between Alberta Health Services and Tribal Chief Ventures Inc.	To support the resourcing of PHC service delivery on-reserves	Preparing Agreements
30. Memorandum of Understanding between Alberta Health Services and North Peace Tribal Council	Alberta Health Services, North Peace Tribal Council	Demonstrates commitments from the provincial government to	Agreement signed between Alberta Health Services and the North	To support the resourcing of PHC service delivery on-reserves	Preparing Agreements

		provide more comprehensive health services for First Nations	Peace Tribal Council		
31. Memorandum of Understanding between Alberta Health Services and Blood Tribe of Health	Alberta Health Services, Blood Tribe of Health	Demonstrates commitments from the provincial government to provide more comprehensive health services for First Nations	Agreement signed between Alberta Health Services and the Blood Tribe of Health	To support the resourcing of PHC service delivery on-reserves	Preparing Agreements
32. Memorandum of Understanding between Alberta Health Services and Siksika Health Services	Alberta Health Services, Siksika Health Services	Demonstrates commitments from the provincial government to provide more comprehensive health services for First Nations	Agreement signed between Alberta Health Services and Siksika Nation	To support the resourcing of PHC service delivery on-reserves	Preparing Agreements
33. Memorandum of Understanding between Alberta Health Services and Alberta Native Friendship Centres	Alberta Health Services, Alberta Native Friendship Centres	Demonstrates commitments from the provincial government to provide more comprehensive health services for First Nations	Agreement signed between Alberta Health Services and the Alberta Native Friendship Centres	To support the resourcing of PHC service delivery on-reserves	Preparing Agreements
34. Truth and Reconciliation Commission of Canada: Final Report	Truth and Reconciliation Commission	Established following the Indian Residential Schools Settlement in 2007	Federal government provided $72 million to support TRC's work between 2007-2015, led to creation of Final Report	To address the legacy of residential schools and advance reconciliation with Indigenous peoples	Interrupting and Re-Imagining Relationships
35. Memorandum of Understanding on	First Nations Health Consortium	Established through the incessant demands of	Agreement signed between the First Nations Health	To ensure that First Nations children and families have	Leveraging Power

Implementation of Jordan's Principle in Alberta	(Siksika Nation, Loon River First Nation, Lubicon Lake Band, Peerless Trout First Nation, Whitefish Lake #459 First Nation, Woodland Cree First Nation, Ermineskin Cree Nation, Samson Cree Nation, Louis Bull Tribe, Montana First Nation, Bigstone Cree Nation); Minister of Children's Services (AB); Minister of Indigenous Services Canada	Indigenous peoples to support the needs of Indigenous children and families	Consortium (11 First Nations), the Minister of Children's Services in Alberta, and the Minister of Indigenous Services Canada	adequate support services, publicly funded health care, and social education programs	
36. Métis Nation of Alberta Framework Funding Agreement	Métis Nation of Alberta, Government of Alberta	Commitment to build partnerships and support the political, cultural, and health rights of Métis	Agreement signed between the Métis Nation of Alberta and the Government of Alberta	To provide a process between the Government and Métis Nation of Alberta to develop respectful relationships and address needs of Métis in the Province	Preparing Agreements
37. Indigenous Health Commitments: Roadmap to Wellness	Indigenous Wellness Core at Alberta Health Services	Commitment of AHS to support Indigenous health at the provincial and local levels	Internal guiding roadmap created by the IWC	To describe structural, procedural, and organizational changes needed to achieve Indigenous health equity	Leveraging Power