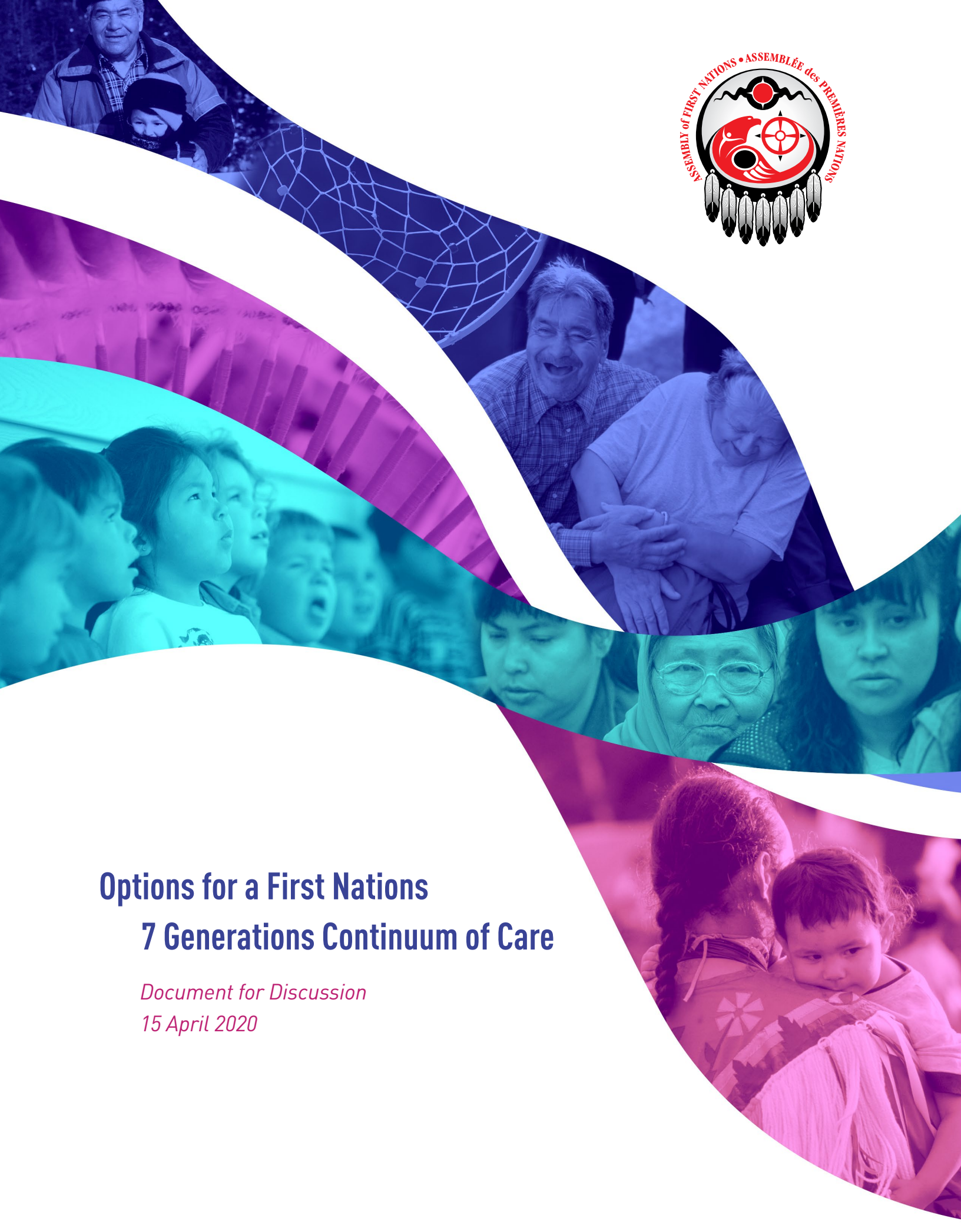

Options for a First Nations 7 Generations Continuum of Care

Document for Discussion

15 April 2020

The work of this report has been carried out on the unceded ancestral territories belonging to self-determining Coast Salish peoples in what is now British Columbia

TABLE OF CONTENTS

TABLE OF CONTENTS

Abbreviations

7GCOC	7 Generations Continuum of Care
ACCHS	Aboriginal Community Controlled Health Services
AGA	Annual General Assembly
ANHRAP	Alaska Native Health Resources Advocate Program
CBHSSJB	Cree Board of Health and Social Services of James Bay
CIRI	Cook Inlet Region, Inc.
CMC	Community Miyupimaatisiiuun Centre
CSH	cultural safety and humility
EHIS	electronic health information system
EHR	electronic health record
FNG	First Nations government
FNHA	First Nations Health Authority (BC)
FPT	federal, provincial, territorial
GBA+	gender based analysis plus
HHR	health human resources
HSO	health service organization
JBNQA	James Bay and Northern Quebec Agreement
MAS	Ministére des affairs
MMIWG	Missing and Murdered Indigenous Women and Girls
NIHB	Non-Insured Health Benefits
OCAP®	ownership, control, access and possession®
OT	occupational therapist

Abbreviations

PT	physiotherapist
RCAP	Royal Commission on Aboriginal Peoples
SCF	South Central Foundation
SDOH	social determinants of health
SLFNHA	Sioux Lookout First Nations Health Authority
SLP	speech language pathologist
TRC	Truth and Reconciliation Commission
UNDRIP	United Nations Declaration on the Rights of Indigenous People
WHO	World Health Organization

Executive Summary

Health services to First Nations are delivered in a complex, multi-jurisdictional environment involving many levels of care, funding sources, health practitioners and delivery models. Despite the numerous obvious contributions of the Canadian health system to the health of the population, from the perspective of First Nations, care is often fragmented or siloed, prone to gaps and breakdowns in communication among the various providers, and can be of variable quality and difficult to navigate. Services obtained from the broader health system outside of First Nations communities may be lacking in cultural safety, and present other barriers to access, for example distance and geography. All of these factors ultimately coalesce in an inefficient and often inequitable health system for First Nations.

This paper is in response to Resolution 19/2019 "Developing a Seven Generations Continuum of Care for First Nations" which was approved at the 2019 AFN Annual General Assembly. This resolution calls for a wholistic approach to develop a continuum of health and health-related supports and services, instead of a program by program approach, which will provide a vision for improved health and wellness for First Nations across the country, and which will be carried forward to benefit seven generations in the future.

A continuum of care means that a person's care is continuous even though this individual may switch between caregivers or care institutions. A continuum looks at the entire environment in the trajectory of that client's care, such as in chronic disease management where services are delivered by different providers in a coherent, logical and timely fashion. A continuum is made up of two related concepts: care which has continuity and care which is coordinated.

- Continuity of Care reflects the extent to which a series of discrete health interventions, services or events are experienced by clients as interconnected and coherent, and which are consistent with their health needs and preferences.

- Care Coordination means that there has been a proactive approach to bringing together health care providers, so that the unique client's needs are fully met, and care is integrated across various settings. [1]

Non coordinated or discontinuous care can have suboptimal outcomes for clients, can result in duplication of effort by care providers, and may increase risk of harm from inadequate sharing of clinical information, even to the point of hospital stays which could have been avoided through better communication and team based approach to care.[2] Certainly, the most vulnerable to these adverse outcomes are those individuals with complex needs

[1] World Health Organization. 2018. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework o

[2] Ovretveit J. 2011. Does clinical coordination improve quality and save money? A summary of a review of the evidence. London: Health Foundation. https://www.health.org.uk/publications/does-clinical-coordination-improve-quality-and-save-money

and those who may already feel marginalized or underserved in the health system due to discrimination or their socio economic circumstance.

National and international agreements, legislation and commissions have provided a supportive context from which a seven generations continuum of care (7GCOC) can be designed and implemented. These include the Royal Commission on Aboriginal Peoples, Commission on the Future of Health Care in Canada (Romanow Report), the United Nations Declaration on the Rights of Indigenous Peoples, Truth and Reconciliation Commission, National Inquiry into Murdered and Missing Indigenous Women and Girls, Accessible Canada Act and the Act respecting First Nations, Inuit and Metis Children, Youth and Families. This body of work speaks to, among other themes, self determination over the health system, the imperative for integration, wholism in the health and social health system which includes Indigenous healing practices, increasing the number of First Nations/Indigenous health providers, achieving substantive equity in both access to health services and outcomes of health interventions, and a targeted approach to addressing the myriad social determinants of health (SDOH).

Characteristics of Indigenous continuum of care models include:

- Accessibility to services through all stages of a person's interaction with health services which encompass perception of needs and desires for health care, seeking health care, reaching the health service, utilizing health care, and the impact of the resulting experience.

- **First Nations governance:** The relationship between self determination, local governance and wellbeing as intrinsic to a First Nations world view of a health system.

- **Culture:** Cultural adaptation in health care linked to the therapeutic virtues of connection to the land; ancestral knowledge and teachings; rites of passage; and skills, habits and beliefs – all of which are considered as essential to Indigenous identity and the survival of knowledge to future generations. A focus on culture in a 7GCOC automatically brings a perspective of First Nations world views on the interconnectedness between the physical, mental, emotional and spiritual realms, and the need to include SDOH, as well traditional healing modalities in transformational change affecting the health system.

- **Partnerships, Collaboration and Integrated Health Service Delivery:** Strengthening of relationships across all jurisdictions and health services based on enhanced collaboration, reciprocal accountability, effective working relationships and mutual respect. Integration in practical terms can be collaborative service delivery, multi-disciplinary teams across jurisdictions, provision of provincial services in First Nations communities, and/or collaborative policy development and sharing of infrastructure and resources.

- **Connections with Social Determinants of Health:** Interventions and practices designed to foster and enhance the health and well-being of First Nations incorporating wholistic concepts of health that move beyond biomedical realms and, instead, address and focus upon social determinants. Approaches must be flexible, address historical and contemporary determinants, and should include decolonizing strategies.

- **Wholism:** Wholistic health care described from multiple perspectives, each representing a portion of the continuum. Wholism refers to a comprehensive and diverse range of health services including prevention and health promotion, health literacy, traditional healing, client advocacy, and SDOH, from support to individuals for housing, education and employment to integrating public health initiatives and collaborating across a broad spectrum of services (e.g. grocers, community councils etc.)

- **Culturally Appropriate and Skilled Workforce:** To support a full continuum of health and social services in a 7GCOC, a range of skills which includes both health and non-health disciplines, optimally provided by First Nations staff. Recognizing that this is a long term process and that there are jurisdictional divides which can impact access to provincial hospital and physician services, the emphasis is on ensuring that the client's initial contact with the health system, and as much as possible of the actual delivery of clinical care, is delivered via a First Nations workforce, or those who have been formally trained in cultural safety and humility (CSH) and the relevant community protocols and understandings necessary for a respectful and fruitful relationship with clients.

- **Incorporate Traditional Knowledge and Practices:** In concert with the increasing awareness of the importance of traditional healing by western based practitioners, embedding this ancient and effective form of health care as an essential characteristic of the model. It is recognized that Nations will have differing approaches to traditional healing and different levels of acceptance within their communities, resulting in the need for a high degree of flexibility in how this will be incorporated into a continuum of care.

- **Capacity and Leadership Development:** To ensure sustainability of a 7GCOC, adequate capacity at all levels of the health system, from employment and training of individuals which will strengthen not just the health system but also the community, to a focus on developing First Nations leaders in the work force who will naturally progress to more senior positions and be role models, and have the capacity and vision to transform the health system to be responsive to the community's needs.

- **Sustainability:** To ensure services benefit generations of First Nations going forward, the ability of the continuum to support new and emerging priorities, population growth, population aging, inflationary pressures, the resolution of inequitable scope of health services, and transformative system change.

- **Cost Implications:** Addressing the inadequacy of health services and need for intensive resources to establish equity in access to health services as enjoyed by the general population. For a population with high and diverse health needs such as First Nations, there will be an early increased utilization and cost to the health system as persons are able to receive needed appointments on a timely basis, have confidence in the safety of needed services so that they are screened for chronic conditions which may require follow up, and if necessary, access treatments for a longer period of time. From the perspective of provincial and territorial health systems, an investment into First Nations primary care can be seen as a prudent course, with expected short term results to be reductions in costly hospitalizations and visits to emergency departments, followed by longer term savings from a healthier population rolling out across a larger sector of the health system.

- **Data and Information:** First Nations Data Governance flowing from and integral to First Nations self-determination, Nation rebuilding and the development of First Nations institutions. A continuum of care model optimally includes mechanisms to facilitate greater access to, and use of, First Nations health data in a respectful and collaborative manner, consistent with the First Nations principles of ownership, control, access and possession (OCAP)®.[3] First Nations control and decision making over how their data and information is collected, analyzed, reported and disseminated is at the core of strategies to restore health and wellbeing of individuals and communities.

Principles of a 7GCOC include:

- **Leaving no one behind:** the continuum embraces all nations and segments of society, including those who are farthest behind and those which are impacted the most because of social, political and economic gaps:

- **Teachings of the seven grandfathers:** wisdom, love, respect, bravery, honesty, humility and truth;

- **Reconciliation:** across all sectors of the health and social system, in a renewed nation-to-nation, government-to-government relationship based on recognition of rights, respect, cooperation and partnership as the foundation for transformative change;

[3] First Nations Information Governance Centre. 2014.

- **Self-determination and local control:** the right and responsibility of First Nations to lead their health and social systems, extending from inherent Aboriginal and Treaty rights which have never been extinguished;

- **Close to home provision of services:** to reduce reliance on travel and dislocation of persons requiring care, through an emphasis on increasing services within communities;

- **Nation voice:** complete Nation participation in health service priority setting, planning and design;

- **Cultural safety and humility:** to create an environment free of racism or discrimination, where First Nations feel safe, can voice their perspectives, ask questions, and be respected by health care professionals on their beliefs, behaviors and values:

- **First Nations world view, evidence based:** which embodies a wholistic, interconnected and balanced approach to life:

- **Person centred care:** where care is designed around the needs of the individual, rather than established structures of disciplines, facilities and clinics;

- **Equity:** within the health system, to ensure that everyone has a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential, to be achieved by providing care which is similar in outcomes and supports to non-First Nations;

- **Two eyed seeing:** seeing from one eye with the strengths of Indigenous knowledge and ways of knowing, and from the other eye with the strengths of Western knowledge and ways of knowing; and

- **Reciprocal accountability:** a shared responsibility amongst all parties to achieve common goals, in a genuine collaboration where each party is responsible for their part of the health system, recognizing that the space occupied by each is interdependent and interconnected.

Interrelated strategies which underpin the continuum include:

- an enabling environment is created, including information systems, educational support, and sustainable adequate resources;

- FNGs and individuals are engaged and empowered through a common vision and commitment by all partners, trust-based relationships, and shared decision making;

- governance and accountability are strengthened across the continuum at all levels from FNGs, health service organizations (HSOs), to regional and provincial entities; and

- services are coordinated within and across sectors.

Two options are presented for a 7GCOC; however, in reality, there are infinite variations as these choices represent opposite ends of a spectrum of approaches to building a continuum. These options, an essential continuum and an aspirational continuum, share many commonalities:

- The 7GCOC is built from community engagement to ensure that it is community-driven and community-based. Community wellness planning is undertaken across all programs areas, with support for organizational capacity development (personnel, information systems, data, and capital). The planning is needs based, uses First Nations and western knowledge, and reflects the circumstances of each particular community, rather than being a generic model.

- CSH is embedded in all collaborations with partners. FNGs work with their provincial/territorial counterparts to develop mandatory courses for all facilities and programs that have a role in health and social care (from policy development to direct provision of services). Furthermore, joint work is undertaken with FPT partners to develop and administer workplans which will create an environment of CSH in the health and social system, for example, spaces within provincial facilities for ceremony and cultural practices such as for birthing.

- The scope of the continuum is broad, encompassing all First Nations, FPT funded health and health related services as well as social programs that have an impact on wellness, including justice, housing, education, and social services among others.

- The continuum is organized around multi-disciplinary primary health care service delivery and administration, with a single entry point and case management. FNGs' community services provide a ready made public health and/or primary health focal point from which to coordinate a larger sphere of services.

- The reach of the continuum's developmental activities is broad, drawing in all practitioners (both with and without the First Nations health system) to facilitate buy in and encourage staff retention. First Nations customs, which stress consensus and consultation, provide an opportunity for a system design strategy which is broadly inclusive of all health providers, and not physician-centric.

- The catchment population in the continuum provides sufficient economies of scale, not only to achieve cost efficiencies in the day to day business, but also to create a buffer for unexpected demands, such as high needs clients whose care requirements might overwhelm an individual FNG's budget.

- Evaluation is not program specific, but rather looks holistically at broad system change using culturally-based indicators that span the breadth of population health from cultural wellness to supportive systems (e.g. food security, acceptable housing, education) to indicators of physical, mental, spiritual and emotional wellness.[4]

- The initial emphasis of the continuum is on network building, rather than the need to 'own' the entire system, as this will allow greater flexibility, a quicker response to needs, build trust between organizations and allow organizations to identify services they provide versus those they obtain from partners.[5]

The continuum spans multiple levels:

- integration of community services, with those which may still have federal administration (e.g. nursing stations) and provincial/territorial services directed to First Nations or Indigenous populations;

- integration of mainstream rural and urban health services with FNG health services;

- integration at the First Nations level among community health service and community sectors such as social services, housing and education; and

- integration between western community health services and traditional healing services. [6]

Organizational Design

The figure on the following page shows a representation of the 7GCOC, with the individual, family and community at the centre, and care wrapped around, beginning with a primary care wellness team that is multi-disciplinary and seamlessly linked with allied health professionals who may be a distance from the primary care team, as well as speciality services, hospital care at all levels and long term care. The primary care team works collaboratively with public and population health providers who focus on wellness, health promotion and illness prevention.

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[4] First Nations Health Authority & BC Office of the Provincial Health Officer. 2020. *First Nations Population Health and Wellness Agenda. Summary of Findings*.

[5] Shortell et al. 1996. *Remaking Health Care in America: Building Organized Delivery Systems*. San Francisco: Jossey-Bass Inc.

[6] Maar M. 2004. "Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario." *Journal of Aboriginal Health*. 1 (1): 54-64.

Adapted from the Primary Health Care ++ model, BC FNHA. Source: FNHA, BC Ministry of Health and Indigenous Services Canada. 2019.

EHR: electronic health record; PT: physiotherapist; OT: occupational therapist; SLP: speech language pathologist.

A continuum of service provision may occur within the community, through mobile outreach programs, hub and spoke style program delivery, and also with partners who deliver specialized care and report back to community-based health providers. The continuum's list of services include prevention, screening, primary health care, home and community care, crisis response, NIHB Program, telehealth and telemedicine, secondary and tertiary care, public health services, traditional counseling and healing, client advocacy, food security, data and information and linkages with health related programs and services.

Option #1: Essential Continuum Model

This option focuses on the integration of services whereby a continuum is created through collaboration and networking of organizations without financial pooling of resources across multiple jurisdictions, tripartite agreements or legislation. Organizations which together provide a full continuum of care partner around common visions and goals, as well as more practical issues of client flow, care protocols and information systems.[7] This is the most common type of a care continuum now in evidence in Indigenous health systems, as FNGs develop protocols and understandings with neighbouring FNGs, non-Indigenous commu-

[7] Leatt P, G Pink and M Guerriere. 2000. "Towards a Canadian Model of Integrated Care." Healthcare Papers 1, 2:13-35.

nities, health authorities, hospitals and private providers for defined services. FNGs may individually negotiate agreements with health authorities or the provincial/territorial government to secure funds that will assist with transformational aspects of developing the continuum, such as mobile mental wellness teams, contracting physician resources, hiring nurse practitioners, and filling gaps in services at the community level. Other agreements may provide the means for FNGs to access provincially held data on their populations, and jointly evaluate health status or institute public health programs of common concern to all parties (e.g. naloxone distribution, cancer screening etc.)

Option #2: Aspirational Continuum Model

The aspirational model is reflective of the vision of RCAP and the Romanow Commission where FNGs administer the majority of the services to their populations much like non-Indigenous health authorities in the provinces and territories. As health care is a provincial and territorial responsibility, and each of the thirteen jurisdictions have their own unique approaches to health care design and delivery at an organizational level, an aspirational 7GCOC will have the greatest impact and reach if it were designed in each jurisdiction independently, with enabling legislation, agreements, policies and protocols.

Formalizing Collaboration

This aspirational model will require a FPT level commitment whereby FNGs, provincial/territorial ministries, and the federal government work collaboratively in the design and delivery of all health services available to First Nations in their jurisdiction, and furthermore, that First Nations models of wellness are integrated into the broader health and social systems.

Federal Legislation

Transformational change of the health system, such as the 7GCOC herein described, is a stated goal of First Nations. In the voices of Chiefs-in-Assembly, this change must be from sickness-based models to First Nations-led systems based in their cultures and through a SDOH approach; from a disregard of First Nations rights, jurisdiction and priorities to respectful and mutual partnerships; and from chronic underfunding to sustainable, long-term investment from federal, provincial and territorial health systems. The mechanism to achieve this transformation will require legislative acknowledgement of First Nations controlled health systems.

A legislative basis for First Nations health will be instrumental in discussions with provinces and territories on their partnerships with, and contributions to, a 7GCOC. Through "Resolution 69/2017 Exploring a Legislative Base for First Nations Health" AFN has been directed to examine options related to federal First Nations health legislation that would articulate federal obligations towards First Nations health, reflec-

tive of inherent, Treaty and international legal obligations, as well as the nation-to-nation relationship. This resolution has mandated AFN to develop tools to aid interested First Nations communities in developing their own positions related to federal legislation on First Nations health.

Funding

The mechanism of funding is another feature of an aspirational model which involves First Nations involvement in health services that encompass those under FNG and FPT jurisdictions. Flexible and consolidated funding was an important recommendation of both RCAP and the Romanow Commissions. Although much of this momentum for change was lost when the newly elected federal government did not carry through with the Kelowna Accord,[8] the concept of block or pooled funding did survive and has been expressed in tripartite health agreements, such as the province wide *Tripartite First Nations Health Plan* in British Columbia.

Across Canada, various First Nations health authority models exist: from the BC experience where the First Nations health organization is separate from the governing structure of the provincial health system, and provincial funding is negotiated on a case by case basis according to mutually agreed upon priorities, to the Quebec experience where the Cree Board of Health and Social Services of James Bay (CBHSSJB) receives funding for all health services within its boundaries from the province, including hospital and physician care, and federal funds previously directly administered to communities. An intermediate model is evident in Ontario, as the Sioux Lookout First Nations Health Authority has much the same arrangement as the CBHSSJB for provincial hospital and physician services, although the federal component has remained separate and is not administered by the province of Ontario.

A geographic-based funding approach which is province-wide and where the First Nations HSOs covers the entire First Nations population would require fundamental realignment of the health system as advocated by the Romanow Commission such as through capitation funding. Capitation financing provides a set amount of money per enrollee and generally uses a formula which, at a minimum, adjusts for the age and sex of the rostered population, and geographic variability in the cost of health goods and services. Other adjusters are population-specific, and for the First Nations population, could include utilization and/or prevalence rates of the most prevalent chronic conditions, functional disabilities, mental disorders/suicides or other community rel-

[8] The Kelowna Accord (2005) was a series of agreements between the Government of Canada, First Ministers of the Provinces, Territorial Leaders, and the leaders of five national Aboriginal organizations in Canada. The accord sought to improve the education, employment, and living conditions for Aboriginal peoples through governmental funding and other programs.

evant health and social indicators. As budget holders in a capitation model, the First Nations HSOs would purchase physician, hospital and other health services for their enrolled members.

Policy Shifts

A fully functional 7GCOC will optimally benefit from policy improvements within federal and provincial/territorial jurisdictions that are centred on a strength-based vision of wellness, allow for a full expression of traditional healing approaches, and build First Nations capacity to assume a greater role in the health system. Examples of policy areas requiring transformational change are midwifery services, traditional healing, wage parity, unregulated community health providers and data/information held by FPT jurisdictions. In addition, a multi-ministry shift is required at all levels and across all sectors, to fully embody the determinants of health as a pivotal strategy to wellness that begins with the individual, and is strength based.

This review of the literature as documented in this report has advanced a model for a 7GCOC which is accessible across all dimensions, built around the person, individual and community, has First Nations governance, is collaborative and integrated into the broader health care system, is wholistic and culturally safe, embeds traditional medicine as an integral aspect of care, is sustainable, and has the data and information needed to effectively manage and evaluate services. It is based on the principles of leaving no one behind, the ancestral teachings of the seven grandfathers, reconciliation with Canadian society, provision of close to home services, CSH, and equity and reciprocal accountability with the mainstream health system. The knowledge system is a blend of the First Nations world view and western scientific contributions to healing through the concept of two-eyed seeing. Its foundation is self-determination of First Nations, powered by strong engagement with all FNGs and their members.

The two options presented represent opposite ends of a spectrum of approaches to building a 7GCOC. In practical terms, an operational continuum may be at various points along this range whereby individual FNG jurisdictions each design a system which is responsive to their own environment and needs. Alternatively, the first option may represent a starting point, from which a more nuanced and elaborate continuum can be designed over time.

Introduction

Health services to First Nations are delivered in a complex, multi-jurisdictional environment involving many levels of care, funding sources, health practitioners and delivery models. Despite the many obvious contributions of the Canadian health care system to the health of the populations, from the perspective of First Nations, care is often fragmented or siloed, prone to gaps and breakdowns in communication among the various providers and can be of variable quality and difficult to navigate. Services obtained from the broader health system outside of First Nations communities may be lacking in cultural safety, and present other barriers to access, for example distance and geography. All of these factors ultimately coalesce in an inefficient and often inequitable health system for First Nations.

As a result of the inability of mainstream health services to effectively and adequately meet the health and wellness needs of Indigenous peoples and to address their marginalization from these services, there are many examples of First Nations or Indigenous specific health service models in existence today, including integrated health authorities in Canada, Aboriginal community controlled health services in Australia, Maori led health initiatives in New Zealand, and health sector wide American Indian and Alaska Native services in the United States. Although these models may not all represent a full continuum of care due to jurisdictional and funding barriers, their essential premise is based on wholistic care across the life cycle and offer a sound base to conceptualizing a fully integrated First Nations continuum of care.

This paper is in response to Resolution 19/2019 "Developing a Seven Generations Continuum of Care for First Nations" which was approved at the 2019 AFN Annual General Assembly (AGA). This resolution calls for a wholistic approach to develop a continuum of health and health-related supports and services, instead of a program by program approach, which will provide a vision for improved health and wellness for First Nations across the country, and which will be carried forward to benefit seven generations in the future.

The intent of the literature and case studies presented in this report is to provide the necessary foundation for the development of thought leadership in a seven generations continuum of care (7GCOC) by a First Nations circle of experts. It builds on the vision established in the First Nations Health Transformation Agenda, the First Nations Mental Wellness Continuum Framework, and other related work, and is aligned with previous AFN resolutions:

- Increased Focus on Disabilities Centred on Human Rights (24/2018)
- Support for the Long Term Implementation of Jordan's Principle (27/2018)
- First Nations Disabilities Program On-Reserve (55/2018)
- Non-Insured Health Benefits: Ongoing Commitment to a Joint Process (74/2018)
- Support the Development of Wholistic First Nations Wellness Facilities (88/2018)
- Federal Engagement on Health Transformation (63/2017)
- Support the Economic, Social and Cultural, Spiritual, Civil and Political Rights of Indigenous Persons with Disabilities (75/2015).

Structure of the Report

The information which has been captured in this report is largely extracted from published and grey literature sources, preferably those which are written from Indigenous experience and insight, but also supplemented from mainstream literature where appropriate and relevant.

The intent of the work is for a First Nations audience, however, in many cases, the literature referenced uses the terms Indigenous and Aboriginal. With respect for these sources, and to ensure that the information is presented correctly, the authors' original terminology has been carried forward where appropriate.

The literature on both a continuum of care and integrated care was reviewed, as integration is an expression of a collaborative continuum. Other closely related concepts are 'continuity of care' and 'care coordination.' These nuances have helped to understand the complexity and interdependencies in a 7GCOC.

With respect to the terminology of persons requiring services in a 7GCOC, the term 'patient' can indicate a hierarchical relationship where the health care provider is placed above the person seeking care. Except in text drawn directly from source reports, this document uses the term 'client' to signify a more collaborative relationship of equal parties, both those providing services and those seeking services, who are working together to improve health and wellbeing.

The report begins by looking at the legacy of First Nations healing and health systems, then describes the continuum of care and its benefits/drivers which are moving jurisdictions to embrace this delivery of care. The supportive legislative environment for a First Nations controlled health system, starting with the recommendations of the Royal Commission on Aboriginal Peoples (RCAP), and ending with the recent passage of the federal legislation to create First Nations laws with respect to child welfare are reviewed.

Characteristics of Indigenous health system models which embody the features of a continuum are presented, which lead into four contemporary models of Indigenous continuums in Canada, the United States and Australia.

Options for the design of a 7GCOC are informed by principles, and a review of lessons learned from health systems that have embarked on increasing integration and coordination of services. Two 7GCOC options are presented – essential and aspirational – beginning with elements common to both, before describing unique elements of each.

Legacy of First Nations Health Systems

When developing a 7GCOC model for consideration by First Nations, the many strengths of First Nations cultures will provide a strong foundation from which to build a forward looking wholistic health service model. Pre colonization, a sophisticated, mature governance system existed in First Nations society. First Nations people had long life spans, as might be expected from living in a healthy environment, in alignment with nature, without the chronic illnesses brought on by western civilization, and the influences of today's technologies, pollution and the like.

Both written and oral history point to First Nations being active, with balanced diets from traditional food sources, resulting in wellness in all domains of spiritual, physical, emotional and mental health. There were many roles for formal healers, and different terminology depending on the Nation or expertise, for example shamans, medicine men, herbal healers and midwives.

In addition to health services, cultural traditions of First Nations societies had a strong protective effect, supporting the various determinants of health. Pre-contact societies supported wellness through customary laws for food and hygiene, small community size, comparatively low population density, reasonable mobility on land and water, seasonal relocations to different harvest locations, intimate knowledge of the local environment, environmentally friendly subsistence practices, and the availability of a variety of foods. The hunting, fishing and gathering lifestyle ensured that people were physically fit, with perhaps the most common chronic condition being age/work related arthritis. First Nations experienced virtually no diabetes and few oral health issues. Other ailments included a limited number of infectious diseases and dermatological problems.[9]

Although tremendously diverse, Nations across Canada shared many commonalities, including subsistence strategies, kinship relations, political structure, and elements of material culture. Belshaw writes in 'The Millenia Before Contact,' that although there were common economic and cultural features across North America, this does not in any way indicate a single monolithic Aboriginal culture. In the northern half of North America alone the number of tongues spoken, artistic techniques perfected, songs and dance styles, architectural and engineering experiments, and systems of government can barely be calculated. [10]

As one example, Dr. James Makokis has summarized the Indigenous structures pre colonization based on Elder teachings of his home community, Saddle Lake First Nation, and contrasted this with contemporary society (Table 1). Counterparts existed to all of today's societal structures – from education (elders) to policing (enforcers and peacemakers) to

[9] https://www.fnha.ca/wellness/our-history-our-health

[10] John D Belshaw. Undated. *Canadian History: Pre Confederation*, Section 2.4 "The Millenia Before Contact" https://opentextbc.ca/preconfederation/chapter/2-4-the-millennia-before-contact/

financial systems (hunters) and health care (medicine men). He has described the impacts of colonization as classism, sexism, genderism, racism, colonialism, neocolonialism, self-hatred, oppression, self medication, loss, and grieving which have been manifested (compared to the general population) as increased morbidity and mortality, increased incarceration rates, social chaos, and decreased graduation rates. [11]

Table 1: Indigenous and Western Structures

Indigenous Structures	Western Structures
Medicine Man	Hospitals
Enforcers	Police
Peacemakers	Sheriffs
Gatherers	Welfare
Hunters	Bankers and Financiers
Headman	Chief and Council
Ceremonies	Churches
Protectors	Army
Elders	Schools
Tribal Law	Indian Act
Natural Law	Canadian Constitution
Extended Families	Social Services

First Nations health systems followed a natural continuum of care, which continues today and which is based on the cycle of life, from pre-pregnancy education and birth protocols which weave in ceremony, to walking out ceremonies for children as they make their first encounter with nature, rites of passage embracing hunting, providing, sexual health and family planning, and the medicine lodge for formal training on medicines and energy work. Dances and ceremonies are used for healing, correcting behaviors, addressing incidents, helping with grief and loss, and passing on teachings. In the words of Dr Makokis, the Indigenous health system is embedded on the land, in ceremonies, songs, language, teachings and medicines. Indigenous health is not pharmaceuticals and doctors, recognizing that these are needed to deal with the social sickness of colonization. [12]

[11] Makokis,J. 2019. Two-spirited Rites of Passage at Summit 2019: https://www.youtube.com/watch?v=_KXidDpVA1M; uploaded November 27, 2019 by the Community Based Research Centre

[12] Makokis, J. 2020. Keynote presentation to First Nations Health Authority Gathering Wisdom X, Vancouver, British Columbia, January 15.

What is a Continuum of Care?

A continuum of care means that a person's care is continuous even though this individual may switch between caregivers or care institutions. A continuum looks at the entire environment in the trajectory of that client's care, such as in chronic disease management where services are delivered by different providers in a coherent logical and timely fashion. A continuum is made up of two related concepts: care which has continuity and care which is coordinated.

- **Continuity of Care** reflects the extent to which a series of discrete health interventions, services or events are experienced by clients as interconnected and coherent, and which are consistent with their health needs and preferences.

- **Care Coordination** means that there has been a proactive approach to bringing together health care providers, so that the unique client's needs are fully met, and care is integrated across various settings. [13]

Health care in Canada is made up of multiple caregivers and care institutions, an environment that demands a continuum for the health system to be fully effective. Good communication is essential between these care points, whether it is documenting the client's experience in a way that is accessible to all information systems that their care may involve, or simply communicating this care among different caregivers in order to assure delivery of appropriate, high quality medical care.

From the work of Haggerty et al. (2003) and Deeny et al. (2017), four types of continuity of care have been described which help to understand what a continuum optimally encompasses:

- **Interpersonal Continuity:** The subjective experiences of the caring relationship between a client and his or her health care professional. Care is received from the same central providers and is adapted to the client's personal situation and environment (e.g. behavioural choices, cultural beliefs, family influences).

- **Management Continuity:** A consistent and coherent approach to the management of a health condition that is responsive to a client's changing needs. This continuity addresses case management and care planning across sectors, a team approach to shared care, and regular monitoring of chronic conditions.

- **Informational Continuity:** The use of information on past events and personal circumstances to make current care appropriate for each individual. As well as the technical aspects of shared information systems and clinical protocols, informational continuity includes the client-provider communication where clients are informed of how and why their care is changing, and the generation of a collective memory relating to the client's care.

[13] World Health Organization. 2018. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework

- **Relational (Longitudinal) Continuity:** the therapeutic relationship between a patient and one or more providers that spans various health care events, and results in an accumulated knowledge of the patient and care consistent with the patient's needs. Examples can include discharge planning, follow up care, referral strategies, care navigators and support by informal caregivers or social network.[14 15 16]

In this document, a broad approach to a continuum is used. It may refer to the continuity within the unit – a specific primary care provider over time and different caregivers within the service all with the ability to exchange information with each other (e.g. during shift changes), or to a continuum of care in the transition from one service unit to another – requiring coordination, collaboration and information transfer between different caregivers in different clinics, hospitals, between wards and facilities within the hospital and in the transition from hospitalization to community health services and vice versa. From a First Nations perspective, the continuum includes social services that are important to wellness and which may be accessed by health providers, such as housing service, employment agencies, the justice system and educational institutions.

Integration

Integrated care was originally thought of as an 'organized delivery system' by Shortell and others in 1993 who described it as "a network of organizations that provide or arrange to provide a coordinated continuum of services to a defined population, and who are willing to be held clinically and fiscally accountable for the outcomes and health status of the population being served." [17]

Valentijn et al (2013) has conceptualized dimensions of integrated care, which are useful to an understanding of what a continuum of care might look like in practical terms. In this model, there are three levels: macro (system), meso (organizational) and micro:

- **Macro level** is where vertical integration describes the *treatment of diseases at different levels*: primary care, secondary and tertiary level services, and horizontal integration features cross sectoral, wholistic based collaborations.

- **Meso level** describes organizational integration, so that the *collective action of organizations* across the entire care continuum (horizontal and vertical) combine in a collective responsibility for the health and wellbeing of a defined population. A second type of meso level integration are the *professional partnerships* which reflect the organizations that are integrated, and have a shared accountability, and complementary competencies, roles and responsibilities.

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[14] Haggerty, J et al. 2003. "Continuity of care: a multidisciplinary review." BMJ 327: 1219-21.

[15] Deeny S et al. 2017. Briefing: reducing hospital admissions by improving continuity in general practice. London: The Health Foundation. https://www.health.org.uk/publications/reducing-hospital-admissions-by-improving-continuity-of-care-in-general-practice

[16] WHO. 2018.

[17] Shortell, S et al. 1993. "Creating Organized Delivery Systems: The Barriers and the Facilitators." Hospital and Health Services Administration. 38:4.

- **Micro level** refers to *clinically integrated care as experienced by individual clients*, which has been coordinated across professional, institutional and sectoral boundaries, and which has drawn in all of the health and social services which will support the wellbeing of the whole person, not just one defined condition. The emphasis at this level is on personal empowerment, so that clients are involved in care decisions, and coordinate their own care where possible. [18]

Drivers of a Continuum

Non coordinated or discontinuous care can have suboptimal outcomes for clients, can result in duplication of effort by care providers, and may increase risk of harm from inadequate sharing of clinical information, even to the point of hospital stays which could have been avoided through better communication and team based approach to care. [19] Certainly, the most vulnerable to these adverse outcomes are those individuals with complex needs and those who may already feel marginalized or underserved in the health system due to discrimination or their socioeconomic circumstance.

The greatest imperative for system reform such as a 7GCOC is to design a health and social system that can effectively address the many, complex health issues facing First Nations, so that the deficit-laden term "health disparities" can be removed from the lexicon of First Nations health. Note: This document will not summarize the health conditions, comorbidities, premature death/lower life expectancy, mental health and substance use issues, among others, which have impacted First Nations wellness profoundly at individual, family and community levels, and which serve as bellwethers of the need to radically transform a health system that is not working optimally for First Nations.

Drivers for a continuum of care can be political, as this is a way for First Nations governments (FNGs) to express self determination through the control of all health and health-related resources in the community. Most certainly, economic considerations are a driver for change, in that finite resources can be applied to priority concerns in a well coordinated system. As the following sections will elaborate, other driving factors for a First Nations continuum of care include providing services which are culturally attuned – which look at wellness wholistically rather than a purely symptom identification approach, including cultural, spiritual and language practices aligned with the population being served, and culturally safe. A continuum of care can overcome a myriad of access issues, and facilitates, through the ability to collaborate and communicate more easily, the adaptation of standard care practices to improve their efficacy among vulnerable populations. Much of the evidence that supports a continuum of care is couched in integration terms, as integration is

[18] Valentijn et al. 2013.

[19] Ovretveit J. 2011. Does clinical coordination improve quality and save money? A summary of a review of the evidence. London: Health Foundation. https://www.health.org.uk/publications/does-clinical-coordination-improve-quality-and-save-money

a necessary intermediary along the path to a full continuum. Integrated health systems have been promoted as a means to improve access, quality and continuity of services in a more efficient way.[20] Integrated care in a First Nations health system can enhance accessibility, create a supportive environment for services, build trust through shared decision making, provide a mechanism to showcase public health programs and raise awareness of the benefits of prevention, and increase cultural humility among health care providers. [21]

Benefits of a continuum of care include higher client satisfaction, cost reductions (e.g. from better use of staff time and less duplication) and importantly, improved health from a wholistic client empowered approach to care.[22] There is also an opportunity to improve equity, as responsibilities for health care are redistributed among the FNGs, provincial/territorial partners, and private contracted providers, as appropriate. As alluded to above, those who benefit the most from a continuum include elderly persons, those suffering from complex medical conditions, mentally vulnerable persons and persons with chronic diseases.[23] Because the relationship between a single health care provider and a client extends beyond specific episodes of illness or disease, it often implies a sense of affiliation with the provider, and fosters improved communication, trust and a sustained sense of responsibility. Continuity may involve a team rather than a single provider, for example in addressing complex chronic conditions and mental health.

An excellent example of an Indigenous continuum of care which covers prevention through hospitalization can be found with South Central Foundation (SCF) and the Alaska Native Tribal Health Consortium, which is an Alaska Native run health system. This model of care will be presented in the case study section that follows. The evidence of how Alaska Native health has improved since Alaska Natives began their health care transformation is compelling. Ensuring a continuum of care was central to this change. SCF has reported positive outcomes since beginning its transformational journey, including improved performance in health system measures as follows:

- **Utilization:** A decrease of more than 40 percent in urgent care and emergency department utilization, 50 percent in specialist utilization and 30 percent in hospital days. This has been attributed to a relationship-based approach, same-day access and better management of chronic conditions.

- **Clinical quality.** Looking at state-produced Medicaid data on children with asthma, their "perfect care" went from 35 percent to 85 percent and hospital admissions dropped from almost 10 percent to less than 3 percent. The number of HIV-positive

[20] Valentijn, P. et al. 2013. "Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care". *International journal of integrated care*, 13, e010. https://doi.org/10.5334/ijic.886

[21] Shrivastava R. et al. 2019. "Patients' perspectives on integrated oral health care in a northern Quebec Indigenous primary health care organization: a qualitative study." BMJ Open. 9:e030005.

[22] World Health Organization. 1996. *Integration of Health Services Delivery*. Report of the WHO, Study Group No. 861.

[23] https://www.health.gov.il/English/Topics/Quality_Assurance/Patient_Safety/Pages/continuity.aspx

individuals admitted to the hospital went from 22 percent to 8 percent. The childhood immunization rate improved from about 85 percent to 94 percent.

- **Access.** By implementing same-day access, SCF reduced the number of individuals on their behavioral health wait list (backlog) from about 1,300 to nearly zero in one year.

- **Customer-owner satisfaction**. Ninety one percent of respondents rated their overall care favourably. [24]

A recent World Health Organization (WHO) review of the continuity and care coordination literature found that:

- coordinated home-based primary care results in 17% lower medical costs;

- over four of five persons with mental health needs can be managed through primary care;

- high continuity resulted in 13% fewer hospital admissions and 27% fewer visits to an emergency department;

- hospital at home models lowered costs by 19%; and

- 23 out of 25 studies of medical home models of care reported reduced use of care. [25]

A 2017 systematic review nine Indigenous integrated health systems included only published, peer reviewed, primary research studies of interventions that demonstrated potential to positively impact quality of health care delivery and health-related outcomes, thereby reducing the disproportionate health burden in Indigenous communities. These nine publications showed that integration had wide ranging and positive results on clients, including improved physical and mental health symptoms, reduced substance use, improvements in education and employment status, as well as a decreased involvement in the justice system. Interventions that additionally integrated culturally relevant health beliefs and practices experienced the largest gains in health outcomes. These studies were able to demonstrate one or more of the following improvements in client care:

- increased access, leading to decreased need for services later;

- increased screening and retention;

- awareness of risk and protective factors and adherence to medical regime;

- increased support;

[24] Gottlieb, K et al. 2008. "Transforming Your Practice: What Matters Most." Family Practice Management.

[25] WHO. 2018.

- more strategies or options for managing their health and life, and decreased utilization of acute services, thus off-setting high cost care; and
- significance and success of their cultural component for improving client care. [26]

A study of First Nations perspectives on integrated First Nations oral health care in Northern Quebec, found that the emphasis on culturally sensitive care with Indigenous personnel in care teams, the development of a more supportive environment and inclusion of parental engagement for oral health promotion resulted, not only in increased client engagement in the care process, but also addressed the historical impacts of colonization such as intergenerational trauma, loss of cultural practice, fear and mistrust, and loss of parenting skills. [27]

Integration of service providers into care teams have shown benefits in dealing with vulnerable populations. A study which assessed collaborative care practices that featured integration of primary care providers, nurses, case managers, clinical pharmacists and psychiatrists for persons suffering from depression, found that racial disparities, where visible minorities (e.g. African Americans, Native Americans) were less likely to respond to standard treatment, were not evident with collaborative, integrated practice.[28]

A culture-centred intervention for HIV/AIDS health services undertaken by the Navajo Nation showed that tribal control, collaboration among multiple parties involved in HIV/AIDS care and incorporation of traditional culture in all aspects of diagnosis, treatment and prevention improved health care access and medical regime adherence of people with HIV/AIDS and increased the risk- and protective-factor knowledge of tribal members at high risk for the disease. [29]

Supportive Legislative Environment

National and international agreements, legislation and commissions have provided a supportive context from which a 7GCOC can be designed and implemented.

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[26] Lewis, M and Myhra, L. 2017. "Integrated care with Indigenous populations: a systematic review of the literature." *American Indian and Alaska Native Mental Health Research*. 88(24) Issue 3.

[27] Shrivastava et al. 2019.

[28] Davis et a. 2011. "Does Minority Racial-Ethnic Status Moderate Outcomes of Collaborative Care for Depression?" *Psychiatric Services*. 62(11): 1282-88.

[29] Duran, B et al. 2010. "Tribally-Driven HIV/AIDS Health Service Partnerships: Evidence-Based Meets Culture-Centred Interventions." *Journal of HIV/AIDS & Social Sciences*. 9:110-129.

Royal Commission on Aboriginal Peoples

RCAP's stated goal was to to close the economic gap between Aboriginal peoples and non-Aboriginal peoples by 50% and to improve social conditions in the next 20 years. The comprehensive strategy was based on a rebuilding process as the best and proper way for the revival of the economic, social and cultural health of communities and individuals. The strategy was premised on the restoration of relations of mutual respect and fair dealing between Aboriginal and other Canadians.

In the area of health and healing, the recommendations were visionary and aspirational, spanning a network of healing centres, government legislation supportive of health sector integration, formation of regional Aboriginal planning bodies, and a comprehensive approach to human resources which would add 10,000 Aboriginal health providers to the health system (Table 2). In the 20 plus years since the release of the five volume report, the report card on the implementation of these recommendations is mixed at best. For example, there has been movement on the recognition of health as core to self-government, and the development of an integrated health system spanning federal, provincial and First Nations jurisdictions in some regions, but a model of Aboriginal healing centres across the country and 10,000 new Aboriginal health providers remains elusive. In totality, these recommendations stand as very complementary to a future First Nations health system that is wholistic, First Nations controlled, based on an Indigenous world view, and fully integrated into mainstream health services.

Table 2: RCAP Health-Related Recommendations

RCAP Recommendation Themes	RCAP #
Recognition of health of a people as a core area for the exercise of self-government by Aboriginal nations	3.3.2
Develop a framework whereby agencies mandated by Aboriginal governments can deliver health and social services under provincial or territorial jurisdiction	3.3.3
Develop a network of healing centres and lodges, operated under Aboriginal control, in both rural and urban settings on an equitable basis	3.3.5,3.3.6, 3.3.9 - 3.3.11
Adapt federal/provincial/territorial (FPT) legislation, regulations and funding to promote integrated service delivery, collaborative FPT and local efforts in health services, and pooling of resources from FPT, municipal or Aboriginal sources	3.3.7
Formation of regional Aboriginal planning bodies in new areas to promote equitable access to appropriate services and strategic deployment of resources.	3.3.12
Develop a comprehensive human resources development strategy	3.3.13
FPT commitment to train 10,000 Aboriginal professionals over a ten-year period in health and social services	3.3.14, 3.3.16
Cooperation to protect and extend the practices of traditional healing and explore their application to contemporary Aboriginal health and healing problems	3.3.21 – 3.3.23

Commission on the Future of Health Care in Canada (Romanow Report)

This vision of an integrated health system supported by block funding was a common theme in community presentations at an Aboriginal Forum sponsored by the National Aboriginal Health Organization and the Commission on the Future of Health Care in Canada in 2002. Its commissioner, Roy Romanow, provided his interpretation of this vision when he recommended in his final report that Aboriginal health funding be consolidated from all sources and be pooled into Aboriginal health partnerships which would manage and promote health services for Aboriginal peoples. These partnerships recommended by Romanow would have a broad mandate, encompassing all levels of health services, and recruitment and training strategies. Key elements of the Romanow partnership model include:

- per capita funding based on the number of persons who sign up to be served by the partnership (capitation), where the funds are obtained from the consolidated budgets in each region, province or territory;
- operation through a fund holder model where the partnership would have responsibility for organizing, purchasing and delivering health care services which are defined based on the scope of the partnership. This could vary from large regional health authorities to community or urban partnerships; and
- a not-for-profit community governance structure with a board comprised of representatives of the funders (all Aboriginal and non-Aboriginal governments) and other individuals involved in establishing the partnership (key organizers, users and health care providers).

United Nations Declaration on the Rights of Indigenous Peoples

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted the United Nations General Assembly on September 13, 2007, and fully adopted by the Canadian government almost ten years later. This declaration is a strong advocacy instrument, even though not legally binding, which can be used to demand and protect Indigenous rights, including the right to health and wellness.

Table 3: UNDRIP Health-Related Recommendations

United Nations Declaration on the Rights of Indigenous Peoples – Health Themes	Article
1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right	24
1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programmes for indigenous peoples for such conservation and protection, without discrimination. 2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent. 3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented	29
1. Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions. 2. In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights.	31

In addition to articles which detail the right to self-determination, to freely determine their political states and freely pursue their economic, social and cultural development, there are three articles which directly address health – the right to health, traditional medicines and practices, environmental protection and intellectual property associated with traditional knowledge (Table 3). Two articles, below, resonate with the multi-jurisdictional, complex health and social environment that a 7GCOC will need to navigate:

- **Article 18:** Indigenous peoples have the right to participate in decision-making in matters which would affect 16 their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

- **Article 19:** States shall consult and cooperate in good faith with the Indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Truth and Reconciliation Commission

The Truth and Reconciliation Commission (TRC) was established in 2008 with the purpose of documenting the history and lasting impacts of Indian Residential Schools on Indigenous students and their families and informing/educating Canadians on this history and its ramifications.

In 2015, 94 "Calls to Action" directed to reconciliation between Canadians and Indigenous peoples were released. Although all its broad reaching calls to action will have a substantive impact on the wellness of Aboriginal peoples when fully enacted, there are seven directed specifically at the present state of Aboriginal health and the health system in Canada (Table 4). The health calls to action confirm Aboriginal health care rights, demand regular reporting of health outcomes, advocate removal legislative differences among Aboriginal groups that lead to inequitable provision of services, reaffirm the RCAP vision of a network of healing centres, recognize the value of Aboriginal healing practices, increase the number of Aboriginal workers, and implement skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Table 4: TRC Health-Related Recommendations

United Nations Declaration on the Rights of Indigenous Peoples – Health Themes	Article
We call upon the 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, constitutional law, and under the Treaties.	18
We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.	19
In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.	20
We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.	21
We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.	22
We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals.	23
We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.	24

Table 4: TRC Health-Related Recommendations

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We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.	22
We call upon all levels of government to: i. Increase the number of Aboriginal professionals working in the health-care field. ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities. iii. Provide cultural competency training for all healthcare professionals.	23

National Inquiry into Murdered and Missing Indigenous Women and Girls

The National Inquiry into Murdered and Missing Indigenous Women and Girls (MMIWG) report is a primer for a fulsome, respectful and comprehensive societal response to the tragedy of the violence against Indigenous women and girls in Canada society, with recommendations directed at all levels of government and Indigenous organizations. The Final Report is comprised of the truths of more than 2,380 family members, survivors of violence, experts and Knowledge Keepers shared over two years of cross-country public hearings and evidence gathering. It delivers 231 individual Calls for Justice directed at governments, institutions, social service providers, industries and all Canadians. As documented in the Final Report, testimony from family members and survivors of violence spoke about an environmental context marked by multigenerational and intergenerational trauma and marginalization in the form of poverty, insecure housing or homelessness and barriers to education, employment, health care and cultural support. Experts and Knowledge Keepers shared specific colonial and patriarchal policies that displaced women from their traditional roles in communities and governance and diminished their status in society, leaving them vulnerable to violence. [32]

Table 5: MMIGW Health-Related Recommendations

Theme 8: The need for properly resourced initiatives and programming to address root causes of violence against Indigenous women and girls	
The need for responsive, accountable, and culturally appropriate child and family services	8a
The need to bridge education (primary to post-secondary), skills training, and employment gaps between Indigenous people and non-Indigenous people	8b
The need to address disproportionate rates of poverty among Indigenous peoples, and Indigenous women specifically	8c
The need to improve access to safe housing (along the housing spectrum, from emergency shelters to secure permanent housing)	8d
The need for accessible and culturally appropriate health, mental health and additions services for Indigenous women	8e
The need to support the continued retention and revitalization of Indigenous identity, including cultures, lifeways, and languages	8f
The need to heal Indigenous male perpetrators of violence and prevent the perpetuation of cycles of gender violence in Indigenous communities	8g

[32] https://www.mmiwg-ffada.ca/final-report

Theme 8, in which health care recommendations are embedded, is directed to ensuring that there are properly resourced initiatives and programs to address root causes of violence (Table 5). The subthemes are child and family services, skills training/education, safe housing, culturally safe health services, revitalization of Indigenous culture, and prevention of the cycles of gender-based violence in communities.

Accessible Canada Act (Bill C-82)

FNGs in Canada are affected by the provisions of the *Accessible Canada Act*. Broadly, it applies to the federal jurisdiction, including Parliament, Crown corporations, the federal government and those federally regulated private sector businesses such as banking, telecommunications and transportation. The intent of the Act is to identify, remove and prevent barriers to accessibility by putting in place new mechanisms to address the systems that uphold these barriers.

Under this legislation, the Government of Canada will develop accessibility standards and regulations in priority areas such as employment, the built environment, and the design and delivery of programs and services. Organizations under federal jurisdiction will be required to follow accessibility regulations and to develop accessibility plans describing how they will identify, remove and prevent barriers across their operations. They will also be required to establish processes for receiving and dealing with feedback about the implementation of their accessibility plan and about any barriers that a person may have encountered in dealing with the organization. Organizations will also have to publish regular progress reports describing the implementation of their plans, feedback received, and how that feedback has been taken into consideration.[33]

This legislation is written from a western paradigm, which may be at odds with how First Nations people view disability, and how a 7GCOC may embrace the needs of persons who are labelled as having disabilities. To begin with, many preventable disabilities can be associated with colonial practices – as the social disadvantages from dislocation, loss of land rights and disruption to traditional livelihoods are catalysts for violence, substance use and mental health issues, all which are correlated with high rates of physical and mental impairment.[34] The numerous inequities which impact First Nations (e.g. lower health status, lesser access to health services, low socio economic opportunities among others), combined with the effects of colonialism, residential schools, and discrimination compound the impact of having a disability on individuals who already occupy a marginalized sector of society, whether Indigenous or not.

[33] https://www.canada.ca/en/employment-social-development/news/2019/06/canadas-first-federal-accessibility-legislation-receives-royal-assent.html

[34] Velarde, M R. "Indigenous Perspectives of Disability." Disability Studies Quarterly. https://dsq-sds.org/article/view/6114/5134

The term disability may be perceived as foreign in Indigenous cultures who celebrate uniqueness and diversity of all individuals and seek to integrate all into their societies. Historically, First Nations governing systems existed with culturally strong and inclusive view of persons with disabilities as the 'gifted ones.' Colonial attitudes over time have distanced First Nations persons with disabilities to the margins of society where they face exclusion, and multiple layers of discrimination based on concepts of race, gender and class.[35] Maori culture embraces differences and impairment as a natural part of being.[36] The Anangu people of Western Australia have a similar concept of impairment as simply a part of humanity.[37] In Mexican Indigenous communities, persons with intellectual impairments were valued and respected members who were recognized for their contributions, rather than being 'deficient' or disabled.[38]

In mainstream Canadian society, all persons with disabilities face similar discrimination and, in some cases, systemic oppression, whether or not they actually see themselves with a disability. The challenge for a 7GCOC which is situated within the Canadian health system, is to integrate services for this unique population in a positive and affirming way into the entire health and social continuum.

Act respecting First Nations, Inuit and Metis children, youth and families (Bill C-92)

On January 1, 2020, the federal legislation Bill C-92, "Act respecting First Nations, Inuit and Metis children, youth and families" came into effect in all provinces and territories in Canada. It has provided the means to change the policies and practices of provincial and territorial child protection authorities, as the section of the *Indian Act* (section 88) which permitted provincial laws of general application to apply on reserve and gave full federal authority behind child welfare agencies to intervene and forcefully remove a child, no longer has force or standing. In its place, First Nations laws with respect to child welfare override provincial and territorial laws, and the consent of these jurisdictions is not required for these laws to come into force.

- Provides the full weight of federal authority to supersede any similar provincial or territorial legislation directed to First Nations children and families.
- Recognizes that First Nations jurisdiction over child and family services is an existing inherent right and does not need to be negotiated.

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[35] *Increased Focus on Disabilities Centred on Human Rights.* Resolution 24/2018. Vancouver: Annual General Assembly, July 24 – 26, 2018,

[36] Hickey, S. 2008. *The Unmet Legal, Social and Cultural Needs of Maori with Disabilities.* (Doctor of Philosophy in Law, and Maori and Pacific Development Studies PhD). Hamilton, New Zealand: University of Waikato. As cited in Velarde.

[37] Ariotti, L. 1999. "Social Construction of Anangu Disability." *Australian Journal of Rural Health.* 7(4): 216-222.

[38] Gotto, G. 2009. Persons and nonpersons: Intellectual disability, personhood and social capital among the Mixe of Southern Mexico. *Disabilities: Insights from across fields and around the world.* Chapter 15, 193-210.

- Provides a comprehensive list of positive standards, which are specific protections for the human rights of First Nations, including care givers and FNGs, meant to respond to the intergenerational trauma caused by colonial policies and practices, and in alignment with UNDRIP standards.

- Attempts to strike a balance between the collective and individual rights of Section 35 of the Canadian Constitution – which will be a new contribution in this area of Section 35 interpretation.

- Includes restrictive or constraining provisions meant to ensure that all service delivery staff throughout a provincial or territorial system, change the way decisions are made about First Nations children. As one example, the Act specifically directs that a child should not be removed due to poverty, lack of adequate housing, lack of adequate infrastructure, or the state of health of the child's parent or care provider.

- Puts the onus on provincial and territorial officials and staff to know and comply with First Nations laws where they have been passed by a First Nations governing body. Provinces and territories cannot develop and impose policies and conditions on who the Indigenous governing body is for First Nations. [39]

Characteristics of Indigenous Continuum of Care Models

A scoping review of Indigenous primary care service delivery models was undertaken by Harfield and associates in 2018. From an initial identification of 2,600 Indigenous articles of primary care models, 62 were selected for analysis. Although primary health care is only one component of a health system, the characteristics of Indigenous primary care systems are transportable to the full continuum of care. The characteristics from this scoping review, which have been adapted and folded into the discussion below, are accessible health services, community participation, continuous quality improvement, culturally appropriate and skilled workforce, flexible approaches to care, wholistic health care, self determination and empowerment. [40]

Accessibility to Services

The ease of which people connect with the care they need for their better health can be considered under the broad heading of accessibility. Having access to care is much more than overcoming geographic barriers or locating services in a way that optimizes attendance by clients (e.g. outreach and mobile service, extended hours of operation, ability to take clients without appointments). It encompasses how acceptable these services are to

[39] Information in this section has been extracted from: Turpel-Lafond, M.E. 2019. *Primer on Practice Shifts Required with Canada's Act respecting First Nations, Inuit and Metis children, youth and families*. Ottawa: Assembly of First Nations.

[40] Harfield et al. 2018. "Characteristics of Indigenous primary health care service delivery models: a systematic scoping review". *Globalization and Health*. 14: 12.

the catchment population, their degree of cultural safety and/or absence of discrimination, in some situations the cost of care (if not covered under the Non-Insured Health Benefits (NIHB) Program or provincial/territorial insurance) and persons' awareness that the services exist.

It follows that accessibility can be increased by health care services which are governed by FNGs, and administered and staffed by First Nations who can provide a racism free environment, offer services in a client's language and, in general, present a more familiar welcoming environment to clients who have experienced barriers with mainstream services.

In Davy et al's framework synthesis regarding access gleaned from the review of these 62 publications "access" of clients was distinguished from "accessibility" which is related to service characteristics. At the same time, the authors noted that access is not a linear concept, rather there is an interconnectedness involving perception, desire to access service, how one actually reaches a service, its affordability, as well as the actual interactions between the client and providers. Furthermore, health practices and policies can greatly affect on how individuals can successfully access care, such as funding decisions that provide for outreach services.[41]

Davy's access and accessibility frames have five stages, which are summarized using the viewpoint of clients and services:

Perception of Needs and Desire for Health Care:

- **Client:** This stage relates to Indigenous peoples' ability to perceive that health care is needed, and overcome denial, lack of self-esteem, and in some cases of substance use where there may be impaired judgement.

- **Service:** Service access related to perception is a combination of awareness (which can be increased by promotion/education and advocacy regarding the services which are available), and the achievement of a positive reputation whereby clients are confident in referring services which are beneficial to their health and wellbeing.

Health Care Seeking:

- **Client:** Individuals may prioritize the needs of others over themselves or be concerned about lack of cultural safety and confidentiality of services, all which can be barriers to seeking health care.

[41] Davy, C et al. 2016. "Access to primary health care services for Indigenous peoples: A framework synthesis." *International Journal for Equity in Health*. 15: 163-71.

- **Service:** To encourage individuals to seek out care, services need to be understood by clients and must represent the values, beliefs and understandings of the communities being served, including local language, gender and Nation alignment. This foundation is built from respect, social justice, participation, equity, access, learning and collaboration. Outcomes are a welcoming environment, culturally appropriate staffing, and wholistic views of wellbeing which incorporate social determinants of health (SDOH) such as food distribution and housing security.

Health Care Reaching:

- **Client**: Transport issues related to location, climate and geography are the main reasons why clients may not reach services, particularly when services are located outside of communities. Poor or absent telephone access is another consideration.

- **Service:** Services can overcome transport and communication issues by delivering outreach programs (rural, urban and remote, in the home, corrections etc.). Outreach services are essential to a comprehensive model of care, particularly for those who live at significant distances from care, and those who are aged or have disabilities. Other ways to improve how people reach services is through providing transport (e.g. responsive policies in the NIHB Program), flexible appointments, extended hours and making electronic health records (EHRs) available to health care providers outside of scheduled appointments.

Health Care Utilization

- **Clients:** Even if all other aspects of access, described above, are rectified, affordability may present another barrier. Although this is less of an issue than in other countries, First Nations people may find services unaffordable if the Non-Insured Health Benefits (NIHB) Program does not cover the cost (e.g. some orthodontic care where coverage has been denied, chiropractic care, other alternative health care providers), if the appointment results in extended time away from employment, or if travel itself is a prohibitive cost.

- **Services:** Again, affordability may be a deterrent to access, from the perspective of communities which are unable to provide the required intensity of care, outreach or other costly improvements due to lack of sufficient funding.

Consequences of Accessing Health Care

- **Clients:** Positive experiences in accessing services helps remove barriers to future care. The ability of clients to engage with health care providers in a meaningful way is enhanced when interacting with Indigenous staff members or participating in cultural activities that the Indigenous health services may provide.

- **Services:** Full engagement by clients is facilitated by a through community needs analysis prior to establishing the service, ensuring community ownership of the service, providing coordinated care wholistically from a multi disciplinary team, and seamless access to care not available within the Indigenous service environment.

First Nations Governance

As encoded in UNDRIP, Indigenous peoples have the right to self-determination, to freely determine their political states and freely pursue their economic, social and cultural development. Indigenous governance of health and social services is congruent with the shared reconciliation agenda between First Nations and other Canadians.

Governance requires ownership of the health and social services which operate within First Nations communities and within urban environments where these services are designed for Indigenous peoples. Governance can be expressed through local representation on governing bodies such as organizational boards. These representatives are then accountable to their communities. The relationship between self determination, local governance and wellbeing is intrinsic to a First Nations worldview.

As one example, FNG autonomy over the health system through a transfer agreement for programs funded by Indigenous Services Canada has been found by Lavoie and associates to be associated with decreasing the rate of hospitalization for ambulatory care sensitive conditions (ACSCs).[42] ACSCs are those conditions where timely and effective primary care can help reduce the need for hospitalization in certain conditions (e.g. diabetes, asthma, cardiovascular disease among others), through either prevention, management of symptoms or controlling an acute episode of illness. [43] In the Lavoie study, the longer the FNG was in a transfer agreement, the better the health outcomes, with the first improvement being seen within a year.

Accountable governance ensures that there is broad and sufficient consultation, engagement and collaboration so that not only do the services reflect community needs, they are culturally appropriate, and accessible, and a two way dialogue exists between the providers and persons they serve (e.g. satisfaction surveys and other ways to solicit feedback). Elders have a valued role in both the provision and governance of services.

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[42] Lavoie, J. et al. 2010. "Have investments in on-reserve health services and initiatives promoting community control improved First Nations health in Manitoba?" *Social Science & Medicine*. 71 (4): 717-24.

[43] Billings et al. 1993. "Impact of socio-economic status on hospital use in New York City." Health Affairs. 12: 162.173.

Culture

Cultural adaptation in health care has been linked to the therapeutic virtues of connection to the land; ancestral knowledge and teachings; rites of passage; and skills, habits and beliefs – all of which are considered as essential to Indigenous identity and the survival of knowledge to future generations.

Culture was seen by Harfield and colleagues as embedded throughout all 62 Indigenous primary health care service delivery models reviewed. Pivotal strategies for including culture include:

- incorporation of local Indigenous cultural values, customs and beliefs, and traditional healing and practices;
- focus on the needs of the individual and on the health and wellbeing of their families and communities;
- respect for women's and men's cultural needs (e.g. gender specific programs);
- ensure the local communities are engaged with, and in control of, Indigenous health services;
- culturally attuned environments: family friendly and welcoming spaces, feature Indigenous artwork and signage;
- culturally appropriate prevention and health promotion resources;
- ability to interact in local Indigenous language, such as through mentors or interpreters who may be members of the local community; and
- educate non-Indigenous staff in local protocols and values and in cultural safety and humility (CSH). [44]

A focus on culture in a 7GCOC automatically brings a perspective of First Nations world views on the interconnectedness between the physical, mental, emotional and spiritual realms, and the need to include social determinants of health (SDOH), as well traditional healing modalities in transformational change affecting the health system.

As one example of the beneficial impacts of cultural inclusion into health care, in an evaluation of a Quebec Cree communities' wellness planning initiative, participants affirmed that reinforcing Cree identity through culturally oriented care (e.g. low risk birthing in the territory) could provide positive motivation for healthy living (e.g. eating well throughout pregnancy to avoid gestational diabetes). [45]

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[44] Harfield et al. 2018.

[45] Lévesque, M. et al. 2019. "Northern Québec James Bay Cree Regional Health Governance in Support of Community Participation: Honouring the 'Butterfly.'" *The International Indigenous Policy Journal*. 10(4): 1-20.

Partnerships, Collaboration and Integrated Health Service Delivery

If viewed from the client's perspective, continuity can be judged by how individual clients optimally will experience integration and coordination of services.[46] Canada's health care system is large, multi jurisdictional, many layered, a combination of public and privately operated components, and overlaid with a generic policy that has never clearly laid out the boundaries between federally and provincially/territorially operated health systems which would facilitate fully serving First Nations needs. The result of this fragmentation has been disjointed health services which may not communicate well, and therefore do not provide individuals with ongoing support so often needed when recovering from serious illness, attempting lifestyle changes, or dealing with chronic diseases.

Layered on top of this often dysfunctional system is the federal government's classification of First Nations which can further create divisions between health services as federal funding is often provided based on numbers of persons resident within First Nations communities. A second criterion may be Indian status eligibility. The First Nations view of a health system encompasses all relevant health needs to their membership living off reserve, and a seamless provision of health services to all persons within First Nations communities regardless of status conferred by the *Indian Act*. Jurisdictional issues do not end at the reserve borders, and urban First Nations individuals often regard available health services as inadequate and not culturally relevant, choosing to visit community services when available and accessible.

The development of an integrated health system is a complex process requiring resources, a community-paced timeline, vision and a long-term commitment to change, sufficient resources and a perceived benefit for all parties. Integration is pivotal in a Canadian continuum of care, whether it be improving communications between organizations, or coordinating various services in different organizations or jurisdictions, or combining all services into one single organization. Thus, integration in practical terms can be collaborative service delivery, multi-disciplinary teams across jurisdictions, provision of provincial services in First Nations communities, and/or collaborative policy development and sharing of infrastructure and resources. Integration has economic benefits when administrative cost-efficiencies are attained that can be reinvested into the First Nations health system. The ultimate expression of integration is First Nations control over sustainable health services which have been transformed through collaborative and integrative improvement, and through relationships with health system partners which ensures meaningful involvement in all aspects of service prioritization, from planning to design and implementation.

In a 7GCOC, all governments must strengthen their relationships with First Nations, based on enhanced collaboration, reciprocal accountability, effective working relationships and mutual respect. Although internationally, examples exist of an Indigenous system which

[46] Haggerty et al. 2003.

spans all health services from first contact with a health provider through to tertiary hospital care (South Central Foundation [SCF] for Native Alaskans in southern Alaska combined with the Alaska Native Tribal Health Consortium would be one example), in Canada, the disjointed funding and governance of health care makes it difficult for a First Nations controlled health system to span the full breadth of services, leading to many variations on what an integrated heath system supporting a full continuum of care would look like.

A 7GCOC should be flexible to accommodate the various parties needed in a full continuum. Starting with FNGs, partnerships may be necessary among individual governments to achieve necessary economies of scale. This could involve community-based services, or in the case of larger affiliations, secondary and tertiary services such as dental health, medical officer of health, nursing supervision, and environmental health services, delivered directly by First Nations or Indigenous organizations. A balance must be struck between the need for community capacity development/local service delivery and the economic considerations found with larger affiliations and centralization of services.

Although the federal government can be now considered mainly as a funder of health services to First Nations, there are still examples of direct federal involvement in service delivery, such as in nursing stations in some regions, and the NIHB Program across all regions except for BC. It is a time of change in the Canada–First Nations relationship, and the federal government has noted that it already has and will continue to facilitate a transfer of its role of both funder and service delivery agent to First Nations communities and health service organizations: "Canada's commitment to achieving reconciliation with Indigenous Peoples through a renewed nation-to-nation relationship, based on recognition of rights, respect, cooperation and partnership, represents a significant shift in the political environment. The principles of reconciliation have been translated into a government-wide framework that supports permanent bilateral mechanisms and ongoing discussions between Indigenous leaders and the Government of Canada."

With provincial and territorial governments having a primary role in the physician and hospital components of the health system, "hardwiring" is a term now used to describe the integration of First Nations health and wellness across all ministry of health priorities and initiatives, and other provincial health partners, in alignment with the vision of UNDRIP and the TRC Calls to Action. In all instances, the success of instituting collaborative relationships will depend on the attitudes, open mindedness and understanding of CSH among all parties who have set aside jurisdictional differences to work on common solutions to health issues and result in a continuum of care. These partnerships will not abrogate or derogate from the Aboriginal or Treaty rights of First Nations protected under section 35 of the Constitution Act, 1982, nor will these partnerships release the Crown from their fiduciary duty to or duty to consult with First Nations on matters that could potentially affect their rights.[48]

[48] AFN. 2017. The First Nations Health Transformation Agenda

Successful Collaborative Relationships

- the relationship is formalised, with clear roles and responsibilities;
- the partners are well chosen, and the expertise, skills, and resources of each are acknowledged and utilized;
- commitment is demonstrated through the application of resources to the partnership;
- the partners share information; and
- the partners demonstrate integrity.

Source: Bell K et al. 2000. "Aboriginal community controlled health services." General Practice in Australia.
https://pdfs.semanticscholar.org/00e8/3ad10bce0812b54651c67f2fbc3320d4deea.pdf

Connection with Social Determinants of Health

SDOH are defined as "the conditions in which people are born, grow, live, work and age – conditions that together provide the freedom people need to live lives they value."[49] These determinants, among others, include peace, income, shelter, education, food, a stable ecosystem, sustainable resources, and social justice and equity.[50]

Health, whether it be physical, mental, emotional or spiritual, is affected by these multiple social determinants comprising circumstances, environments, structures, systems and institutions. A framework for social determinants uses the following categorization:

- **Distal** – historical, political, social and economic contexts, e.g. colonialism, racism and social exclusion, self-determination.
- **Intermediate** – community infrastructure, resources and capacities, health care systems, educational systems, environmental stewardship, and cultural continuity.
- **Proximal** – health behaviours, physical environments, employment, income, food security, education. [51]

[49] Commission on Social Determinants of Health. 2008. *Closing the gap in a generation: Health equity through action on the social determinants of health Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization*; p. 26

[50] World Health Organization. 2012. *The Ottawa Charter for Health Promotion*. Geneva: World Health Organization

[51] Reading C and F Wien. 2009. *Health Inequalities and Social Determinants of Aboriginal Peoples Health*. National Collaborating Centre for Aboriginal Health. Prince George: National Collaborating Centre for Aboriginal Health

It follows that interventions and practices designed to foster and enhance the health and well-being of First Nations require wholistic concepts of health that move beyond biomedical realms and, instead, address and focus upon social determinants. Greenwood and Leeuw (2012) have offered the following discourse on how SDOH might be effectively addressed:

- Approaches must be flexible, address historical and contemporary determinants and should include decolonizing strategies. These approaches must underpin all medical and psychosocial interventions aimed at bettering health and well-being. Interventions should account for broader contexts and distal determinants that continue to influence the context and, thus, individual health. These broad contexts require collaborations across and between sectors and disciplines; medical or even health sectors alone cannot address or influence these determinants of health and must work in concert with other sectors such as education, child welfare, housing and justice, among others.

- Awareness must be created of the social and historical context in which Aboriginal peoples find themselves through the education and training of professionals that interact with Aboriginal people on a daily basis. For example, development of a curriculum for the training of health professionals should go beyond presenting Canada's Aboriginal peoples as having poor health status and experiencing substandard social and economic conditions – particularly if those poor health statuses are attributed only to biomedical or physiological failings. This will help prevent the adoption of common, social stereotypes about Aboriginal people, particularly among uninformed students. Specific cultural competency/safety training should be put into place for health practitioners who are working with or are intending to work with Aboriginal people. Greenwood notes that this type of education opens opportunities for transmission of knowledge to other disciplines and even broader society. [52]

First Nations practices and social innovation are premised on healing and abundance for the individual, the family, the community and the nation with the wholistic principle "no one does well until we all do well." It would be disingenuous to think that a 7GCOC can be successful in significantly improving wellness in First Nations in isolation from actions to improve the socio-economic circumstance of FNGs and the people they represent.

As an example, the Nisichawayasihk Cree Nation (Nelson House) in Manitoba is marrying economic development with their goals to heal the community from trauma, improve employment opportunities and create better living spaces through infrastructure development and energy self reliance. This Nation's focus has been on nurturing its young people.

[52] Greenwood, M and Leeuw. 2012. "Social determinants of health and the future well-being of Aboriginal children in Canada." Paediatric Child Health. 17(7): 381–384.

Through a comprehensive approach to social enterprise (employment creation, environmental protection, social development and income generation), the Nation has ensured that trained youth will be supported as they enter their careers, in this case, in construction. [53]

Starting with an apprenticeship class in the construction trades in 2017, where students successfully won a contract to build two homes, the Nation now has a for profit construction company (Pewapun) which hires First Nations apprentices and bids on contract opportunities. In that first contract, the following benefits were achieved:

- trainee incomes rose from $311 per month in social assistance to $3,338 per month as first year apprentices;
- students were able to apply this work to their on the job training requirements as apprentices.
- the income earned was circulated within local businesses;
- building materials were purchased from a local First Nations business where possible, causing a further circulation of earned income;
- saved social assistance resources were reallocated to other community needs; and
- in alignment with the Nation's Strategic Plan, the construction used alternative energy sources (solar) and other construction options that reduced heat loss and the possibility of mould growth. [54]

By 2018, Pewapun had logged over 67,000 person hours of employment for 35 citizens. At apprenticeship wages, this was $1.3 million in earnings retained and recirculated in the community.[55] Although in this example, the direct connection with a 7GCOC may not be immediately obvious, it is through these broad approaches to improving socio economic conditions in First Nations populations, will be pivotal to the achievement of the overall goal of better health and wellness.

[53] Deane L and C Szabo. 2020. *Nisichwayasihk. A Future Net-zero First Nation*. Winnipeg: Canadian Centre for Policy Alternatives Manitoba Office.

[54] Deane 2020.

[55] Deane 2020.

Wholism

Wholism is a term used almost interchangeably with First Nations approaches to health and wellness, and to some extent, might be considered a synonym for a 7GCOC. Wholistic health care can be described from multiple perspectives, each which is a portion of the continuum:

- Comprehensive health care that supports individuals, and their families and communities, and includes physical, mental, spiritual and emotional aspects of wellbeing;
- diverse range of services to clients: prevention and health promotion, chronic disease care, maternal and child health, oral health, ear health, sexual health, mental and social health; alcohol and other drugs treatment, pharmaceutical services, aged care and disability services;
- prevention and health promotion initiatives, tailored to individual communities: screening programs, healthy lifestyle programs, needle exchange programs, women's and men's health programs, healthy eating, exercise and smoking cessation programs, oral health, injury prevention, and supporting people to manage their own health;
- improving health literacy, such as early warning signs of suicide, increasing HIV/AIDS awareness, providing information about alcohol, tobacco and other drug related harm, understanding food labelling, maintaining health and ensuring that people can detect early warning signs and understand when to seek health care advice;
- traditional healing;
- client advocacy as they move through various levels and aspects of the health system;
- SDOH support for clients in accessing housing, employment, education, social security payments and supporting people through the justice system;
- advice in relation to public health initiatives not within the normal scope of mainstream health care, such as sanitation system construction and maintenance, disease surveillance, environmental health, food distribution and transportation; and
- collaborations with other organizations such as schools, youth groups, prisons, disability and aged care services, and with councils, liquor outlets and grocers to reduce the supply of harmful products while increasing the availability of healthy options. [56]

[56] Harfield et al. 2018.

The situation of people with disabilities, and the often inadequate response of various sectors of society to meet their needs in a dignified, respectful and empowering way, offers a perspective on how the dynamic of a 7GCOC focused on wholism should shift to looking at rights of people, not their physical manifestations. If the health model of care is broadened to a social model, then the focus moves from 'fixing' to empowering individuals, respecting their human rights and providing the means to heal not just the person, but the environment which surrounds them. This can be facilitated by a compassionate human rights-based approach written into all policies and procedures, such as what underlies Jordan's Principle.

Culturally Appropriate and Skilled Workforce

To support a full continuum of health and social services in a 7GCOC, a range of skills is required which includes both health and non-health disciplines, optimally provided by First Nations staff. Recognizing that this is a long term process and that there are jurisdictional divides which can impact access to provincial hospital and physician services, an emphasis can be to ensure that the client's initial contact with the health system and as much as possible of the actual delivery of clinical care is delivered via an First Nations workforce, or those who have been formally trained in CSH and the relevant community protocols and understandings necessary for a respectful and fruitful relationship with clients.

First Nations, particularly if they are from the same community as where their employment is located, may assume additional responsibilities in the health care continuum such as liaison, informal mediation and interpretation skills within the health system. Employing advocates and cultural translators in all health care facilities can provide relational bridges of understanding between the health care system and the Aboriginal people interfacing with it. [57]

Staff development and retention of First Nations health workers require the development of career laddering opportunities, and the provision of support for training in more advanced roles within the health system. At a system wide level, investments are required in accreditation of First Nations training institutions, partnership development, academic standards, new education opportunities including innovative approaches to providing community-based training offering minimal relocation or disruption to the student, school counselling and back filling positions while persons are being trained. [58]

Larger health service organizations may develop strategies with member communities and educational institutions to encourage and mentor First Nations students into health careers or collaborate on a provincial level to establish bridging programs that would allow First Nations staff with minimal formal health education to enter accredited programs of study.

[57] Greenwood and Leeuw. 2012.

[58] AFN. 2019. First Nations Health Action Plan, draft.

Incorporate Traditional Knowledge and Practices

Traditional healing refers to health practices, approaches, knowledge and beliefs incorporating First Nations healing and wellness while using ceremonies; plant, animal or mineral-based medicines; energetic therapies; or physical/hands on techniques.[59] Often these are used in combination: physical conditions can benefit from the healing properties of plants and animals along with energy based modalities, whereas issues related to mental, emotional or spiritual domains might be first addressed through healing ceremonies.

In concert with the increasing awareness of the importance of traditional healing by western based practitioners, the 7GCOC will embed this ancient and effective form of health care as an essential characteristic of the model. It is recognized that Nations will have differing approaches to traditional healing and different levels of acceptance within their communities, resulting in the need for a high degree of flexibility in how this will be incorporated into a continuum of care.

One area of consensus is the imperative to recognize cultural skills within the broader health system, through equitable resourcing and wages, so that culturally-based programs are on an equal footing with mainstream health programs provided by non-First Nations health services. [60]

Capacity and Leadership Development

To ensure sustainability of a 7GCOC, capacity must be adequate at all levels of the health system, from employment and training of individuals, preferably First Nations, which will strengthen not just the health system but also the community, to a focus on developing First Nations leaders in the work force who will naturally progress to more senior positions and be role models, and have the capacity and vision to transform the health system to be responsive to the community's needs.

Building this capacity will require true partnerships with mainstream organizations which may have been more comfortable in the past directing services to First Nations rather than collaborating with FNGs. Engaging and collaborating with provincial services is labour intensive, as it is generally seen as an add on to existing roles. Consideration for this essential capacity development requires adequate resourcing of First Nations health systems and representative organizations so that front line health providers need not assume a greater burden that could lead to burnout or the need for stress related leaves.

[59] https://www.fnha.ca/what-we-do/traditional-healing

[60] AFN. 2017.

Sustainability

A 7GCOC will require assurance that services and relationships will support the breadth of a health service continuum, benefiting generations going forward. Therefore, services must be sustainable, and able to accommodate new and emerging priorities, population growth, population aging, and inflationary pressures. This will require the development of financial escalators which can accommodate these cost drivers, and in the population aspect of funding allocations, the inclusion of all community members who access services, not just those counted as status and recorded as living on reserve. In essence, to recognize that Nations can determine their own membership. [61]

If the First Nations escalator is indexed to annual growth in the provincial and territorial health systems, the indexing needs should be adjusted for not just higher First Nations need, but also the resolution of the inequitable scope of services now available to First Nations communities, and to support system change so that transformative, responsive and effective services can be designed and implemented.

The inability of some First Nations health systems to offer competitive salaries to those received by employees of federal, provincial or territorial governments is a long-standing issue. Wage parity concerns appear regularly in studies, environmental scans, and strategies which seek to improve recruitment and retention of First Nations-based health workers. In FNGs, wage parity requires fiscal sustainability and is a major factor affecting workforce stability along with ensuring a manageable workload and providing adequate infrastructure and support to staff.

Cost Implications

The anticipated long-term outcome from transforming a health system to be a responsive continuum will be a population which has improved access to health and social services at an earlier stage of need, resulting in improved wellness and eventually less demand on the system. Cost containment certainly has been a motivating force in the development of regional health authorities in the Canadian health service landscape which are seen to be more responsive to their constituency, and able to realize cost efficiencies through program design and economies of scale. For example, as of September 2013, 131 Canadian health care organizations had endorsed principles from the Institute for Healthcare Improvement, which has a triple-aim framework of system design in three areas related to integration and continuity of care: better care (improving the client experience of care), better health (improving the health of populations) and better value (reducing the per capita cost of health care). [62]

[61] AFN. 2017.

[62] Canadian Nurses Association (CNA), Canadian Medical Association (CMA) and Health Action Lobby (HEAL). 2013. Integration: A new direction for Canada's Health Care: A report of the health providers' summit process. Ottawa: CNA

Even though the long term vision for a health system which moves towards a continuum is promising for reducing costs, this is not the case for FNGs in the short term, as services are presently inadequate and intensive resources are needed to establish equity in access to health services as enjoyed by the general population. For a population with high and diverse health needs such as First Nations, there will also be an early increased utilization and cost to the health system as persons are able to receive needed appointments on a timely basis, have confidence in the safety of needed services so that they are screened for chronic conditions which may require follow up, and if necessary, access treatments for a longer period of time. From the perspective of provincial and territorial health systems, an investment into First Nations primary care can be seen as a prudent course, with expected short term results to be reductions in costly hospitalizations and visits to emergency departments, followed by longer term savings from a healthier population rolling out across a larger sector of the health system. Continuity of care, as expressed by attachment to a primary care practitioner, has been shown to result in cost savings to the health care system, which generally means that there has been less reliance on higher cost services such as hospitalizations, emergency department utilization and the use of drugs. [63]

There is some evidence to suggest that a piecemeal approach to transforming the system, rather than whole system change, will not translate into cost savings. An $80 million demonstration project in the Unites States which was designed to test whether a continuum of mental health and substance use services for children and youth was more cost effective than services delivered in a more typical fragmented system showed interesting results. Certainly, the new system had better access, greater continuity of care, more client satisfaction and children were treated in less restrictive environments. Not surprisingly, the cost was higher. This was determined by the researchers to be due to the clinical judgement embedded in the model whereby clinicians and their managers could place children in the 'most appropriate' level of care for the 'most appropriate' length of time. Children had longer treatment and were given more expensive intermediate level services without a reduction in the use of traditional services (e.g. outpatient and hospital care). Readers should keep in mind that these results are in part a reflection on how the demonstration project services were financed. A continuum of care model where costs have been controlled by capitation or other fixed cost model of financing could have different results. In this project, the results were deemed to not be cost effective as clinical outcomes were no different than in a control comparison site, leading the researchers to suggest that system reform should be broader than the mental health system to affect change. [64]

[63] Hollander MJ and Kadlec H. 2015. "Financial Implications of the Continuity of Primary Care." The Permanente Journal. 19(1)

[64] Bickman, L. 2014. "A Continuum of Care: More is Not Always Better". American Psychologist. 51(7): 689-701.

Data and Information

First Nations are self-determining and have a right to data on their populations. First Nations Data Governance flows from and is integral to First Nations self-determination, Nation rebuilding and the development of First Nations institutions, and is a hallmark of reconciliation.

A continuum of care model optimally includes mechanisms to facilitate greater access to, and use of, First Nations health data in a respectful and collaborative manner, consistent with the First Nations principles of ownership, control, access and possession (OCAP)®.[65] First Nations control and decision making over how their data and information is collected, analyzed, reported and disseminated is at the core of strategies to restore health and wellbeing of individuals and communities. Governments have historically handled and managed First Nations data in ways that have not recognized their inherent sovereignty over data about their peoples. In the past, First Nations data has often been collected, interpreted, reported and used without First Nations knowledge or explicit permission, generally in the absence of an accurate understanding of its context and without comprehension of alternative interpretations, or regard to First Nations principles, values and traditions.

Data and information must also be timely to allow a government or organization to course correct where necessary when implementing a new approach, such as a 7GCOC. The First Nations Health Authority in BC was stymied in the quantitative aspects of their evaluation of the progress in increasing First Nations wellness as a result of their transformative agenda, even though they are now in their seventh year of operation. Due to the lag time associated with identifying First Nations information in provincial health databases which would allow them to look at changing patterns of access to hospitals and physicians – because of the need for agreements, incompatibility between public and private privacy legislation, and the backlog in addressing data linkages in part due to the lack of adequate provincial analytical resources dedicated to meeting First Nations need for information, as of the end of 2019, the most recent data available was for the first full year after the creation of the FNHA (2014/15).

All parties in a 7GCOC should share a mutual desire to facilitate the greater and timelier access to, and use of, First Nations health data in a respectful and collaborative manner, consistent with OCAP® principles, as a means to support the identification of opportunities, innovation, and solutions directed to service delivery improvement and ultimately better health and wellbeing. Data governance means a community-driven, Nation-based approach which recognizes that First Nations may have diverse needs related to how they access and use data.

[65] First Nations Information Governance Centre. 2014.

The four OCAP® principles of ownership, control, access and possession apply to all First Nations data, irrespective of its physical location. In a 7GCOC, effective data governance means:

- FNGs have access to the data they need to effectively provide health and social services, can strengthen their ability to directly work with and utilize, health data identifiable to their populations;
- All partners support First Nations decision making in the governance of First Nations data. This involves in partnership with the First Nations owners;
- First Nations data is culturally, appropriately and respectfully collected, analyzed and used in accordance with First Nations principles, values and traditions.
- First Nations data is reported within a culturally safe wellness paradigm and incorporates culturally appropriate understandings in the interpretation and reporting of this data. External partners in a 7GCOC disclose all data products in a manner where FNGs or their mandated data stewards lead their initial release to the First Nations constituency; and
- the desires of FNGs to hold data on their populations is honoured by all partners. This can involve a range of options that technology provides for FNGs and their data stewards that may allow for a virtual possession of health data, or alternatively, partners may become data stewards for FNGs, and thereby eliminate the need to physically house large amounts of data.

Research and Evaluation

Research and evaluation in a 7GCOC should be aimed at improving the lives of First Nations people based on collaborative, respectful and equitable partnerships between FNGs and the academic sector. Greenwood and Leeuw write that recognizing multiple ways of knowing and being in the world is fundamental to effective research and effective health care practice, with and for Aboriginal peoples. OCAP® principles are also necessary in research endeavours involving First Nations and provide the means to ensure that the studies conducted are informed by First Nations vision and leadership, wholism, active community participation, strengths-based orientation, and reinvigoration and revitalization of their cultures. [66]

[66] Greenwood and Leeuw. 2012.

Models of Indigenous Continuums of Care

South Central Foundation

SCF is an Alaska Native-owned, non-profit health care organization serving nearly 65,000 Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Borough and 55 rural villages in the Anchorage Service Unit. Incorporated in 1982 under the Tribal authority of Cook Inlet Region, Inc. (CIRI), SCF is the largest of the CIRI non-profits, employing more than 2,500 people in more than 80 programs.

SCF administers the Nuka system of care - an array of primary care, dentistry, behavioural health, complementary medicine, traditional healing and home based services which, and along with the Alaska Native Medical Centre operated by the SCF and the Alaska Native Tribal Health Consortium, represents a totally integrated Indigenous health care system with a full continuum of care.[67] The Alaska Native Medical Centre includes a 173-bed hospital, a full range of medical specialties, primary care services and labs. The hospital houses Alaska's first Level II Trauma Center and is also a Level II Pediatric Trauma Center. In addition, the Alaska Native Health Resource Advocate Program (ANHRAP) assists Alaska Native people and their family members by identifying, locating and connecting with appropriate and available health, social, educational, legal, employment, disability, treatment, housing, health insurance, and other related programs and/or services.

Table 6: Services Offered Through South Central Foundation

ANHRAP	Family Health Resources	Pediatrics
Audiology	Family Wellness Warriors Initiative	Pharmacy
Behavioural Health	Health Education	Physiotherapy, occupational therapy, and exercise
Child and Family Developmental Services	Home Based Services	Primary care clinics
Complementary Medicine	Learning Circles	Research
Dental Services	Native Men's Wellness	SCF detox
Elder Program	Obstetrics and Gynecology	Soldier's Heart
Emergency Department	Optometry Services	Traditional Healing Clinic

ANHRAP: Alaska Native Health Resource Advocate Program
Source: https://www.southcentralfoundation.com/services/

[67] Information in this section has been obtained from: Gottlieb, K et al. 2008. January. Note: based on a site visit by the author in summer 2019, this information is current.

When Alaska Native leadership made the decision to assume health services from the Indian Health Service, it carefully entered into whole system transformation founded on the values, wants and needs of Alaska Native people.

Early on, the SCF planners realized that a flaw in mainstream health services was that many departments and programs operated independently, with everyone doing what they deemed to be the best within their own boundaries – a model that works well for short, time limited conditions, but is not effective for the entire trajectory of a long term condition, from prevention and wellness, to treatment, maintenance and continuing care. As a result, many of the day to day decisions on implementing a practitioner's treatment plan, whether it be taking medications compliantly or modifying lifestyle habits are really in the domain of the client, with little or no influence by the health care provider. The SCF model became about relationships among human beings more than simply ensuring that clients had access to tests, diagnoses, pills and procedures.

Rather than speak of patient-centred care, which puts persons in the centre, but still subordinate to all of the professionals who surround them, SCF developed the term " customer driven" and the organization responds to their customers needs, goals and values. The philosophy is to put services into culture, rather than culture into services. On a practical level, this means that services, functions and advice are integrated into individual's lives on their terms, in a personal partnership with their primary health provider.

SCF utilizes small integrated primary care teams, each with a core membership of physician, medical assistant, nurse and nurse assistant who forge a trusting, accountable, long term relationship, and bring in other health care providers when needed (e.g. tribal doctors, traditional healers, chiropractors, massage therapists and acupuncturists). Addressing behavioural issues is seen as one of the most transformational parts of the SCF approach, and thus behaviourists are incorporated into the primary care team.

The primary care system provides same day access which has been achieved through full scale system change. Functions are assigned to staff according to skills, phone consultations and email are used when it makes sense, and the physician is not a bottleneck needing to see everyone. Even specialists are expected to be available on a same day basis, often during a client's appointment, via a call from the physician.

SCF recognizes that staff members and supporting infrastructure are vital to success, and all processes have been designed to support and empower staff, from recruitment, training, supervision, to team meetings etc. Primary care teams are evaluated monthly on dozens of clinical measures, including performance of the team as well as customer-specific measures (which persons are overdue for services, have been hospitalized etc.) Same day hiring occurs, which reduces unnecessary delay and provides a competitive advantage in a tight employment market. Importantly, every new hire goes through a weeklong orientation, to learn about SCF processes, philosophy and Alaska Native people and cultures.

Aboriginal Community Controlled Health Services, Australia

In Australia, Aboriginal Community Controlled Health Services (ACCHS) have been established as practical expressions of Aboriginal self-determination in Aboriginal health. In the ACCHS model, participatory wholistic primary health care has integrated illness care with disease prevention, intersectoral collaboration and advocacy for social justice.

An ACCHS is defined as an incorporated Aboriginal organization, which has been initiated by a local Aboriginal community and is based in the community and governed by an Aboriginal board of directors that is elected by the local Aboriginal community. An ACCHS delivers wholistic and culturally appropriate health services to the community by which it is controlled.

In 1996, in response to the insufficient amount of funding provided by the Australian government to meet the high level of unmet need in Aboriginal primary care, ACCHS were granted the legal ability to bulk bill under Medicare. As well, Aboriginal health services in remote areas, both government and non-government administered, are supplied with pharmaceuticals on a bulk supply basis through community pharmacies. The community pharmacy is then reimbursed directly by the country's Health Insurance Commission.

In its integrated primary care model, physicians are ultimately responsible to the community, and work closely with other providers, particularly Aboriginal health workers and nurses. Physicians have an opportunity to help implement population-based approaches to public health problems, support Aboriginal community development, support skills transfer by becoming involved in Aboriginal health worker training, and advocate for improvements in environmental conditions. It should be noted, that in smaller ACCHSs, Aboriginal health workers play a lead role in clinical and other work such as health education, liaison, referrals and training, as these services usually do not have access to on-site medical, dental or nursing care.

The scope of ACCHS services includes coordinated preventative health care interventions, health promotion, mass screening, advocacy and transport services. For example, letters of support are provided for clients who need public housing, who face eviction, and other services include emergency food aid for families in need, accommodation at a safe house or women's shelter for those affected by family violence, free medications and/or handling the client's co payment at the local pharmacy, and repatriation of those who have died away from their communities. [68]

In 2017, a Health Care Home trial was implemented in the ACCHS model.[69] This Health Care Home provides a systematic approach to chronic disease and complex condition management in primary care. It features the continuation of the team approach to care,

[68] Bell K et al. 2000. "Aboriginal community controlled health services." General Practice in Australia. https://pdfs.semanticscholar.org/00e8/3ad10bce0812b54651c67f2fbc3320d4deea.pdf

[69] Health Care Homes: Handbook for general practices and Aboriginal Community Controlled Health Services. February 2019. https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-cp/$File/HCH-Handbook-Feb-2019.pdf

along with a bundled payment model. Clients can voluntarily enroll in a practice and nominate a clinician (physician or nurse practitioner) who leads the team in providing ongoing care. In much the same way as the SCF Nuka model, clients (consumers) are encouraged to participate in and direct their own care, becoming genuine partners with the team.

Funding is via capitation, with the Health Care Homes receiving a monthly bundled payment for each enrolled patient, paid according to the patients' assessed risk. In 2019, there were three levels of risk according to complexity:

- Tier 1 - Multiple chronic conditions (10% of the population): clients are largely self managing
- Tier 2 - Multi-morbidity and moderate needs (9% of the population): requiring clinical/non-clinical coordination and supported self-care
- Tier 3 - High risk chronic and complex needs (1% of the population): high level of clinical coordinated care; one fifth of this group may be best supported with palliative care program

Tier 1 has the lowest level of capitation payment, with Tier 2 about double the Tier 1 amount, and Tier 3 about triple the Tier 1 amount. Allied health and physician specialists receive remuneration via fee for service billing.

As accessing primary care is not tied to a fee-for-service payment, the Health Care Homes can utilize a variety of ways to extend access to their rostered client population, including in-hours telephone support, email support, video conferencing, open scheduling, after hours' access, small group health and lifestyle coaching, shared medical appointments and monitoring symptoms remotely through new technologies.

Cree Board of Health and Social Services of James Bay

The James Bay Cree are a population of about 18,000, most of whom live in the nine communities of Eeyou Istchee (James Bay). The area is vast and remote, with large distances between communities (up to 1,000 kilometers) and present the typical challenges of living in northern isolated geography. As with other First Nations in similar geographic environments, there are many factors related to poor health status and socioeconomic conditions that have a profound effect on individual, family and community wellness.

The Cree Board of Health and Social Services of James Bay (CBHSSJB)[70] is responsible for the administration of health and social services for all persons residing either permanently or temporarily in Region 18, the administrative region of the Ministry of Health and Social Services of Quebec corresponding to the Cree territory of James Bay. It provides an example of a fully integrated, First Nations administered, health care system that operates within the provincial legislative space, providing a substantial component of the continuum of care.

[70] https://www.creehealth.org/services

The catalyst for the creation of the Cree Board was the Province of Quebec's desire in the 1970s to establish the James Bay hydro project which would flood hunting territories and cause the loss of way of life for Cree communities in the flood zone. The Cree communities agreed to collaborate with similarly affected Inuit communities to fight the hydro project. This intervention eventually transitioned to the negotiation of a landmark self-government agreement, the *James Bay and Northern Quebec Agreement* (JBNQA). Section 14 of the agreement contains a provision for the establishment of Cree and Inuit health boards to be locally operated with the support of the Quebec health and social services ministry. These boards were modelled after the Regional Health Boards that were established in the Province of Quebec in the 1970s.

In this agreement, Quebec assumed primary responsibility for health and social programmes to the Cree. This meant that the Health Canada transferred its facilities in the Cree Region to the Ministère des affaires sociale (MAS), who, in turn, transferred them to Cree control. The MAS assumed the costs for programmes and services formerly administered by Health Canada through a fiscal arrangement with the federal government. Section 14 also has a provision to ensure "the continuation of federal programmes on reserve lands held by the Crees on the same basis as with other Indians;" however, in the views of the James Bay Cree, this has not always happened. [71]

Today, the Board's mandate and its operations are defined in the Quebec legislation: *Chapter S-5 An Act respecting health services and social services for Cree Native Persons*.[72] It covers the nine Cree communities in Eeyou Istchee. This is the only health and social institution in Quebec governed by its own legislation.

[71] Torre, J et al.2005. The Evolution of Health Status and Health Determinants in the Cree Region (Eeyou Istchee): Eastmain-1-A Powerhouse and Rupert Diversion Sectoral Report Volume 2 Detailed Analysis. Chisasibi, Quebec: Cree Board of Health & Social Services of James Bay, https://www.creehealth.org/sites/default/files/Evolution%20of%20Health%20status...CBHSSJB%20Sectoral%20Report%20Volume%202.pdf

[72] https://www.creehealth.org/sites/default/files/Evolution%20of%20Health%20status...CBHSSJB%20Sectoral%20Report%20Volume%202.pdf

Table 7: Health Services and Programs of CBHSSJB

- Cree non-insured health benefits
- Dentistry: Nine community-based dental clinics provide emergency services as well as standard dental procedures such as cleaning, filling, x-ray and extraction. Specialty services, such as root canals and crowns, are centralized in two communities.
- Disability Services (formerly Special Needs): family-centred, community-based, multi-disciplinary approach to special needs
- Family Group Conferences: for family and social situations that may concern family support, rehabilitation of children, requests for accommodation, children with disabilities, parents with a life-threatening illness or child protection. Restorative conferencing is also being used in such situations as victim-offender mediation, circle sentencing, reintegration, diversion, school infractions, domestic violence, conflict circles, family disputes, elderly placements or community issues.
- Foster Resources & Child and Family Protective Services: Foster Home Resources helps to provide a safe and secure home environment for children and youth who are not currently living in their own homes.
- Maanuuhiikuu (Mental Health): Regional Department of the Cree Health Board is responsible for planning and organizing access to mental health services for Cree beneficiaries under the JBNQA.
- Midwifery/Birthing
- Multi-Service Day Centre: therapeutic programs and services to the elderly and adults with special needs.
- Telehealth: offers ophthalmology, obstetrics and psychiatry services in community.
- Wiichihiituwin: organizes medical appointments, transportation, meals and lodging for Cree beneficiaries who need to travel outside Eeyou Istchee for medical services
- Women's Shelters (Robin's Nest): two shelters supporting coastal and inland communities
- Youth Healing Services: four facilities with treatment beds, family-based care integrated with the education system; incorporates a holistic land-based program

The health infrastructure comprises a hospital and nine Community Miyupimaatisiiuun Centres (CMCs). The Chisasibi Regional Hospital has a medical team of 7 doctors and 27 registered nurses providing acute care, pediatric, chronic care and respite care services. Services include laboratory, dental department, radiology department, hemodialysis unit, archives, liaison department, physiotherapist and nutritionist services, pharmacy, and a regional program of infection prevention and control. It provides specialist services through a partnership with RUIS McGill. Through this partnership, specialists from McGill University Health Centre, Jewish General, St. Mary's, and Douglas Hospitals visit Chisasibi Regional Hospital and provide telemedicine services in obstetrics, surgery, paediatrics, orthopedics, internal medicine, ophthalmology, otolaryngology and psychiatry.

Last fall (2019), $300 million in funding was announced by the Quebec government, as part of a new five year agreement with the CBHSSJB. This funding will result in a new regional health centre (seven times the existing facility size), and across the territory, two additional birthing centres, three Elders' homes (intermediate and respite care), mental health resources, and information technology improvements. As well, specialists in cardiovascular health, oncology and mental health will visit communities to see clients. Three new CMCs will be built offering front line services and community health care.

The new hospital will be combined with a CMC and will integrate traditional Cree healing practices. It will have a range of services previously unavailable in the territory, such as surgery, chemotherapy, CT scans, gynecology and obstetrics, dental care, mental health, addictions treatment, and sleeping disorder diagnosis.

Other services currently provided by the CBHSSJB are shown in Table 7.

The establishment of the CBHSSJB has ensured that Cree are involved in the administration, design and delivery of a broad range of health and social services. As of July 2018, approximately 40% of management positions at CBHSSJB were held by Cree [73].

A 2017 Provincial Commission of Inquiry into the relationship between Indigenous peoples and certain public services in Quebec resulted in a report detailing the challenges to the provision of health services to the James Bay Cree. These included medical transportation of clients to regionally based services, recruitment and retention of qualified health professionals, and the long medical stays away from home required by some clients, who must live in an unfamiliar non-Indigenous environment. Due to the language of the JBNQA, the nine communities are islets (Category 1 lands) and are situated within a larger provincial administrative region. Jurisdictional ambiguities cause uncertainty in the provision of services, for example, which jurisdiction looks after ambulance services, should the CBHSSJB participate in secondary health services in the larger region? The Commission noted that the existing regional hospital can handle semi-urgent and uncomplicated urgent needs,

[73] Lévesque. 2019.

with those more critical being stabilized before sent to a hospital outside the territory, weather permitting.[74] It would appear that the recently announced funding of a new hospital is directed to resolving at least some of the issues related to the Cree's need for a higher level of care.

In 2013, support and training occurred for the nine remote Cree communities to develop and sustain wellness committees that could undertake local strategic planning and collaborate with the regional health authority to address community priority health determinants. An evaluation was completed on this planning process which defacto included both the Cree communities and the provincial health system, and resulted in the following findings which are important to a discussion of a continuum of care:

- Issues of collaboration and communication will be addressed through breaking silos (e.g. the band, the school board and the health system), ensuring cultural adaptation and safety in health care, and developing local planning structures in the communities. Breaking silos will be key to addressing health and social issues outside of the sole jurisdiction of the health board (e.g. education and housing), for balancing regional professional services with local knowledge and expertise, for fostering trust in community members, and for avoiding practices that my be associated with oppressive colonialist governance. Communication from the perspective of building relationships and understanding each other's lived realities and contexts is closely related to breaking silos.

- Other communication challenges are associated with the fear of sharing information and knowledge about individuals and community practices, of inadvertently reinforcing stigmas and negative stereotypes, of exposing traditional medicine to cultural theft and appropriation, and effectively translating health information to community members.

- Local community wellness committees are instrumental in obtaining grassroots community voice and input on health services and program delivery, identifying community health and wellness priorities, and improving the coordination of community entities around shared goals. [75]

[74] Provincial Commission of Inquiry into relations between Aboriginals and certain public services in Quebec. 2017. *Health and social service challenges to offering services adapted to the needs of the James Bay Cree.*

[75] Lévesque. 2019

Sioux Lookout First Nations Health Authority

Sioux Lookout First Nations Health Authority (SLFNHA), established in March 1990, provides a range of health services and client advocacy to 31 First Nations communities, of which 80% are only accessible via air and ice road. The catchment population is over 30,000 individuals and growing. Between 2011 and 2031, the population will be expected to rise by 30%. The land mass is extensive, including two treaties, two time zones, and two provincial public health units.[76]

SLFNHA works under the direction of First Nations' leadership, in accordance with its goals of self-government and self-determination, to represent and address the health needs of the 31 communities in the Sioux Lookout area. It places a high priority on the functions of:

1. Coordinating the delivery of high quality, culturally sensitive health care service;
2. Playing a leadership role in the development of First Nations health policy;
3. Facilitating advocacy of clients' rights and wishes;
4. Educating health care providers and recipients of their rights and responsibilities within a changing health care system; and
5. Integrating the planning and provision of individualized, community-based and institution-based health and social services. [77]

SLFNHA's mandate includes federally funded programs supplemented by provincial funding, and in the future, will fold in the nursing stations that are still federally administered as well as the oral health program, also federally run.

Its member communities are health system partners and have their own administrative processes and staff. Community-based health services are supplemented by SLFNHA's three primary care teams which receive provincial financial support, and by other programs (see Table 7). These integrated primary care teams have physicians and allied health professionals and work directly with community-based health providers. (A fourth team is under development and will serve the entire population of the town of Sioux Lookout.) SLFNHA is working to overcome the silos inherent in federal programs – and, to that end, has integrated primary care with mental health & addictions and developmental services (special needs). The intake and referral processes are being streamlined, and they are moving towards an electronic health information system.

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[76] This case study has been drawn from the SLFNHA website (www.slfnha.com), an interview with the SLFNHA executive director, and the following documentation: (1) SLFNHA. 2019. *Approaches to Community Wellbeing: A First Nations Public Health Model*; and (2) SLFNHA. 2006. *The Anishinabe Health Plan.*

[77] https://slfnha.com/about/history

SLFNHA administers and supports the physicians in its territory including those who work in the hospital, with full management services from recruitment and contracts to remuneration.

In the 2006 Anishinabe Health Plan developed for the SLFNHA, public health was identified as a major gap. Following in 2010, the Chiefs-in-Assembly mandated SLFNHA to develop a regional public health system. A pivotal component of the developing regional public health system has been the staffing of a public health physician funded by Indigenous Services Canada and Ministry of Health and Long Term Care and seconded to the SLFNHA from the Thunder Bay District Health Unit. This position has no legislative authority, rather provides an essential role in building linkages to the provincial system and providing a focal point for the development of regional collaborative approaches.

Table 8: SLFNHA Health Servicest

- **Family health:** prenatal, child and parental health. Training undertaken in Traditional Indigenous Family Parenting, Indigenous Doula training, and how to conduct home visits
- **Youth:** resources for youth, including a network, workshops, community events, trainings and conferences. Mentorship for youth workers. Partnership with Carleton U on fostering youth resiliency
- **Healthy relationships:** from parenting to youth-elder relationships
- **Infectious Diseases:** prevention and control, health promotion, tuberculosis, Hepatitis C, Harm reduction. Future goal to control case and contact mgt of reportable diseases.
- **Chronic Disease Prevention: i**n a developmental stage, have looked at food security initiatives, developed a diabetes regional strategy
- **Regional Wellness Response Program:** focus on mental wellbeing and additions, support for communities
- **Public Health Physician:** liaison with provincial system as well as with communities and First Nations organizations.
- **Physician Services/Northern Clinic:** SLFNHA management and administration
- **NODIN CFI services:** mental health counselling, linkages to school and community, incorporates traditional healing and western approaches, crisis response.
- **Indigenous Interprofessional primary care team:** nurse practitioner, physiotherapy, occupational therapy, Nutrition, Kinesiology, social work, speech language therapy, pharmacy consultation, case mgt, psychiatry
- **Developmental disability services:** complex care case mg (< 18 yrs.); Transitions Program (>18 yrs.)
- **Client Services:** hostel, discharge planning and discharge travel; research projects.

The values that drive the work of the SLFNHA are the teachings of its people, language and history, family, wholism, honouring choices and respecting differences, sharing knowledge, the connection to the land, and supportive relationships and collaboration. The roots of community wellbeing are planning and evaluation (including community engagement), policy, ethics, capacity development (of communities and health providers), communication, ethics, data collection & analysis, and research.

The most important factors or enablers that have helped SLFNHA move towards a continuum of care are the ability to fully assess the needs of each community, and secondly to have received additional resources which supplemented the physician model of care and which funded Jordan's Principle services. The latter funding allowed SLFNHA to address the back log of special needs services for children.

A key challenge in the expansion to include public health in the SLFNHA model has been bridging western and Indigenous perspectives and understandings – for example, trying to rationalize the compartmentalization of public health into the frame of a wholistic approach to community wellbeing. Other challenges include:

- Remoteness of communities makes it difficult to reach all equally;
- Sustainability is an issue as funding is short term. Compounding this is the reality that transforming public health takes time for improved outcomes; yet funding is results-driven;
- A lack of public health standards for First Nations due to the two federal and provincial jurisdictions over health services and the on/off reserve residence of the population;
- Ambiguities with respect to legislation and authority over public health in First Nations communities. No federal legislation exists in this area, the applicability of provincial legislation is unclear, and SLFNHA does not have authority for public health under any legislation. As a result, SLFNHA must rely on provincial health units to implement aspects their plan; and
- Data needed to assess outcomes and progress to improved individual and community wellbeing must be negotiated with provincial data holders.

Principles which have helped drive the SLFNHA's progress to a continuum of care are:

- Community voice;
- Positioning services as close to home as possible so that clients can avoid travel;
- Increasing level of services within the community to include preventative care and chronic disease management;
- Increasing the Indigenous workforce; and
- Capacity building: Focusing on existing community staff to increase their skills and knowledge, for example, providing training for community workers so they can monitor and intervene where appropriate, in the care of clients with diabetes and thereby prevent complications. Community workers with training in specific areas can be integrated into their communities' health teams and will have more responsibility to support health professionals. This staff development also supports career laddering in that individuals can advance in their careers while still working in their Indigenous health system.

Going forward, SLFNHA sees one of their greatest challenges to be mental health and addictions, as funding is insufficient, the needs are great, and treatment beds are limited. In a related area, progress has been made due to Jordan's Principle which has addressed the backlog of psychologist assessments for children and youth and moved them into the treatment stream. With the initial work on a public health system being completed, future efforts are focused on setting up a communicable disease program, determining how their public health officer can be directly employed by the authority, building stronger links with social services, further developing their environmental health program, and developing community reports that take a broad systems focus.

Principles of a 7GCOC

Leaving No One Behind

The United Nations 2030 Agenda and its Sustainable Development Goals are premised on the principle of Leaving No One Behind and its applicability to all nations and all peoples, and to all segments of society including those who are farthest behind and those which are impacted most because of social, political and economic gaps.[78] This principle has been woven into the AFN's Social Innovation and Social Finance actions[79] and is foundational to all areas of health and social services. The AFN AGA resolution 24/2018 which is specific to disabilities, has embedded Leaving No One Behind, when it mandates the AFN to advocate for disabilities as a central issue in all policy and program sectors, to ensure an intersectional lens/disability analysis is applied to program and policy areas, new initiatives and budgets, and to have an increased focus on disabilities in international processes of Indigenous and humanitarian value, including the climate change agenda, and implementation of the Sustainable Development Goals.

In more general terms, 7GCOC's structure and founding principles must be designed through a vulnerability lens – if all segments of society which are high risk for any reason are truly served well by the health and social system, then it will work for all. A population is vulnerable if it has a high level of physical, psychological, and/or social risk. On an individual level, vulnerable persons include those persons with disabilities who can be double, or even triple marginalized (by their disability, their ancestry and perhaps their gender affiliation), lesbian, gay, bisexual, transgender, queer, intersexed, agender, asexual, and ally (LGBTQIA+), persons experiencing poverty, children (in particular those who live in low income households), pregnant women, the elderly, the homeless, those with human immunodeficiency virus (HIV), and those with other chronic health conditions, including severe mental illness.

The Government of Canada has mandated all federal ministers to undertake a Gender-Based Analysis Plus (GBA+), an approach designed by Status of Women Canada which draws in many lens/identities in addition to gender. The following graphic provides a good representation of what a GBA+ includes, and reinforces the many segments of society that must be considered in any program and service directed to serving the entire population if truly not leaving anyone behind:

The 'identity factors' wheel showing all the different identities that must be considered by government workers in crafting policy.

From: Status of Women Canada [80]

[78] United Nations Committee for Development Policy. 2108. *Leaving no one behind*. Report on the twentieth: Official Records of the Economic and Social Council. Supplement No. 13 (E/2018/33).

[79] Assembly of First Nations Social Innovation and Social Finance: First Nations Approaches in Leaving No One Behind. Summary & Actions at a Glance. 2020.

[80] https://nationalpost.com/news/what-is-gba-the-federal-intersectional-doctrine-that-governs-everything-now

These identity factors in the above figure may resonate differently with various sectors of the population. For example, the AFN has heard in its Nation engagements that the biggest disability is associated with cultural deprivation, that persons with disabilities often feel cut off from community and have a desire to reconnect with culture.[81]

A lens which is suggested by the identity factors wheel, but not made explicit, is the decolonization lens which seeks to expose and counter underlying Western-based assumptions, motivations and values. Such a lens looks critically at programs, services, from their administration to the treatments that are provided, with a view to reversing the dominant society's delegitimization of Indigenous ways of knowing in favour of exclusively western knowledge paradigms. The decolonization lens seeks to claim and reclaim First Nations ways of being, validate First Nations storytelling, oral history and traditional medicine, offer traditional treatments that are complementary to mainstream medicine, document the survival and strength of First Nations people rather than their demise or assimilation, and first and foremost, deemphasize the role of the settler as the primary actor in anti-colonial and decolonizing actions.[82] Western based policies which are the real 'disability' in a First Nations health system are replaced by those which align with First Nations principles of wholism, wellness, leaving no one behind, seven grandfather teachings, and others offered herein.

Teachings of the Seven Grandfathers

The Anishinaabe people provide ancestral teachings on how humans should conduct themselves with others. These teachings of the seven grandfathers are:

- **wisdom (Nbaakaawin):** to cherish knowledge is to know wisdom
- **love (Zaagidwin):** unconditional love, mutually given
- **respect (Mnaadendmowin):** to honour all of Creation. By giving respect, one receives respect
- **bravery (Aakdehewin):** to have a fearless heart and do what is best with integrity, even if it is difficult or the consequences unpleasant
- **honesty (Gwekwaadziwin):** in word and action, to oneself and others
- **humility (Dbaadendizin):** as a sacred part of creation, we are all equal, with no one better
- **truth (Debwewin):** is to know all of these things, to speak the truth without deception[83, 84]

[81] Interview with Marie Frawley-Henry, February 20, 2020.

[82] Fortier, C. 2017. "Unsettling Methodologies/Decolonizing Movements." *Journal of Indigenous Social Development.* 6(1): 20-36.

[83] http://www.nandecade.ca/article/cultural--teachings-133.asp

[84] http://www.treaty3.ca/pdfs/grandchief/gct3/seven_teachings.pdf

Reconciliation

Given that the current state of First Nations health in Canada has been the result of a destructive legacy injustice, inequality, and inequity towards Indigenous peoples from the forces of colonization, any attempt to design a 7GCOC which is inclusive of the Canadian health and social services system will require as a primary principle, a commitment by all parties to reconciliation. In the voice of the TRC, reconciliation is coming to terms with events of the past in a manner that overcomes conflict and establishes, going forward, a respectful and healthy relationship between Indigenous and non-Indigenous peoples in this country. [85]

The primacy of reconciliation in all collaborations involving First Nations and the Canadian health and social service systems has been validated by the commitment of the Government of Canada to achieving reconciliation in a renewed nation-to-nation, government-to-government relationship based on recognition of rights, respect, cooperation and partnership as the foundation for transformative change.[86] Reconciliation now is a term being applied to Indigenous/non-Indigenous collaborations and partnerships at all levels of Canadian society, founded on mutual recognition and respect. It will be important in a 7GCOC for all partners to fully understand what reconciliation means on a practical basis in the health and social system, so that appropriate benchmarks and measures can be established to chart progress.

Self-Determination and Local Control

As encoded in the *UNDRIP*[87] which has been ratified by the FPT governments, Indigenous peoples have the right to self-determination, to freely determine their political states and freely pursue their economic, social and cultural development. UNDRIP's focus on developing and maintaining institutions in all areas of Indigenous society and governance is pivotal to First Nations self-determination.

It is the inherent right and responsibility of First Nations to lead their health and social systems, as the most qualified to articulate and plan for their communities' health needs. [88] This right to self-determination over their health and social practices/systems extends from their inherent Aboriginal and treaty rights, which have never been extinguished, where pre-contact, First Nations had total control over complex and diverse health practices and wellness activities.[89]

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[85] Truth and Reconciliation Canada. 2015. *Canada's Residential Schools: Reconciliation. The Final Report of the Truth and Reconciliation Commission of Canada, Volume 6*. Montreal and Kingston: McGill-Queen's University Press. http://caid.ca/TRCFinVol62015.pdf

[86] https://www.justice.gc.ca/eng/csj-sjc/principles-principes.html

[87] *United Nations Declaration on the Rights of Indigenous Peoples.*

[88] AFN. 2017.

[89] AFN. 2017.

First Nations also have the right to enact their own laws. The *Indian Act* provides that First Nations bands may enact by-laws with respect to, among other sectors, the health of residents on-reserve. [90]

Close to Home

An outcome of ensuring local control over health is that services can be organized close to home, so that there is less reliance on travel and/or dislocation by clients who require health care. Analyses of First Nations utilization of primary care providers often shows that First Nations, compared to other residents, are less likely to have continuity of care with the same health professional. They are also much less likely to be provided care close to home. [91] In acknowledging the gap in health outcomes between Indigenous and non-Indigenous Canadians, the federal government in its 2018 budget noted that providing access to quality health care close to home – "keeping families healthy in their communities" is an essential part of a strategy to close that gap. [92]

Nation Voice

Complete Nation participation in health service priority setting, planning and design will facilitate the development of an effective, responsive health system, and facilitates equitable distribution of resources. A community voice ensures a democratic process, creates a climate of empowerment that leads to acceptance and trust of the health system, and provides assurance that the priorities and values of a community have been heard and adopted. [93]

Within a First Nations continuum of care, incorporating the voice of the entire Nation is an ongoing process of engagement, rather than an outcome. As First Nations assume administration over a greater portion of the health system, the need for economies of scale will drive centralization of services in some sectors, for example, mental wellness teams, and will require multiple FNGs' perspective and approval to be successful. Community engagement can also provide focal points to bring First Nations and non-First Nations partners together, such as that undertaken by the CBHSSJB when it established community wellness committees to undertake local strategic planning and collaborate with the regional health authority to address community priority health determinants. [94]

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[90] Boyer, Y. 2014. *Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers*. Saskatoon: Purich Publishing Limited.

[91] Manitoba Centre for Health Policy (MCHP), in partnership with the First Nations Health and Social Secretariat of Manitoba. 2019. *The Health Status of and Access to Healthcare by Registered First Nation Peoples in Manitoba. Winnipeg*: Manitoba Centre for Health Policy.

[92] https://www.budget.gc.ca/2018/docs/plan/chap-03-en.html

[93] Lavoie, J et al. 2012. "Regionalization as an Opportunity for Meaningful Indigenous Participation in healthcare: Comparing Canada and New Zealand." *The International Indigenous Policy Journal.* 3(1); article 2.

[94] Lévesque. 2019.

Although most inclusion of First Nations perspectives have historically been in the context of services within their own borders, recently, provincial governments have been mandating Indigenous voices in their health services more broadly. As an example, In British Columbia, each of the five regional health authorities (RHAs) have signed partnership accords and developed action plans with the First Nations Health Authority (FNHA) to provide a coordinated approach to governance undertakings, in relation to diverse topics, with the goal of achieving substantial progress on matters of shared priorities. As well, the BC Ministry of Health Service Plan for 2019/20 – 2021/22 includes:

- In the primary care model under development: continue to work and collaborate with FNHA, First Nations and Indigenous partners to support the integration of Indigenous primary care health services with the Primary Care Strategy delivery; and
- When ensuring effective population health, health promotion and illness and injury prevention services: continue to work with health authorities, FNHA, Métis Nation BC and other health system partners to support the commitment to culturally safe health services across the health system as per the Declaration of Commitment to Cultural Safety and Humility in Health Service Delivery for First Nations and Aboriginal People in BC; and continue to support true and lasting reconciliation with Indigenous peoples by fully adopting and implementing the UNDRIPP, TRC Calls to Action and the Métis Nation Relationship Accord II. [95]

Cultural Safety and Humility

Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care. Cultural humility is a process of self-reflection to understand person and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.[96]

Colonization had a destructive effect on First Nations cultural, economic and health systems. Through the seizing of land and enforced settlement of Indigenous people on small, often barren land, decimation of political and economic self-determination, imposition of government policies intended to marginalize and destroy the social fabric of First Nations society, and loss of children to residential schools and foster care, a profound distrust was engendered in all Canadian facets of life, including health and social services. This distrust remains today and, in the health system, is reinforced by racism and racist stereotypes, jurisdictional divisions which are perceived as denial of needed services, and simple ignorance of well-meaning but poorly informed service providers.

[95] British Columbia Ministry of Health. 2019. 19/20 – 2020/21 Service Plan. https://www.bcbudget.gov.bc.ca/2019/sp/pdf/ministry/hlth.pdf

[96] Johnson, H. 2020. *Cultural Safety and Humility Presentation to the Canadian Institute for Health Information*. January 17.

The concept of cultural safety arose from the colonial context of New Zealand society. In response to the poor health status of Maori and their insistence that service delivery change profoundly, nursing in that country began a process of self examination and change in nursing education, prompted by Maori nurses. Nursing and midwifery organizations moved to support this initiative as something which spoke more sincerely of New Zealand society. Cultural safety became a requirement for nursing and midwifery courses in 1992.[97] In Canada, one example of the championing of cultural safety and humility is the BC FNHA which has been instrumental in provincial and federal ministries associated with health, health authorities in the province, health regulators of various professions, and other organizations signing declarations of a commitment to CSH. [98]

In a culturally safe and humble health care system, there is no racism and discrimination. First Nations people feel safe when accessing health care; they can voice their perspectives, ask questions, and be respected by health care professionals on their beliefs, behaviours and values. Through a complete understanding of their health situation and treatment options, First Nations individuals are the main decision-maker in regard to their health care.[99]

First Nations World View, Evidence Based

The 7GCOC recognizes a First Nations worldview, which embodies a wholistic, interconnected and balanced approach to life. Measures to understand health and wellness, where possible, are not deficit-based and instead honour First Nations strengths and point towards the attainment of greater health at an individual, family, community, population and Nation level.

The First Nations ways of understanding, sharing and informing, which are captured and transmitted through storytelling, and other qualitative ways are living records and are as equally valuable as mainstream approaches, which primarily use quantitative data to understand the health and social needs of a population.

Person-Centred Care

In the words of the SCF in Alaska, the client/customer drives everything. This may be a somewhat obvious principle: the continuum of care should be designed around the needs of the individual. However, it is a fact that the Canadian health care system is largely bricks and mortar and made up of different health provider 'units.' In this complexity, the uniqueness of each individual and their health and wellbeing concerns can be lost through the

[97] Papps, E and Ramsden, I. 1996. "Cultural Safety in Nursing: The New Zealand Experience". *International Journal for Quality in Health Care* 8(5):491-7

[98] https://www.fnha.ca/wellness/cultural-humility

[99] First Nations Health Authority. #It Starts with Me. *FNHA's Policy Statement on Cultural Safety and Humility.* https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf

system's need to conform to established structures of disciplines, facilities and clinics. In contrast, by placing the person as the pivot around which all services flow and are aligned, the system will include mechanisms for linkage between all sectors, and any one individual is less likely to' fall between the cracks' as the cracks have become bridged.

Equity

The World Health Organization defines equity as the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.[100]

Much has been written about the inequitable health status of Indigenous peoples, both within Canada and internationally, which spans higher prevalence of chronic and infectious diseases, various traumas and injuries both intentional and non-intentional, and interpersonal violence including at the domestic level, with all of these factors culminating in a high morbidity and mortality/low life expectancy paradigm made even more urgent by high infant mortality and youth suicide rates. The social inequities, which are beyond the reach of traditional health systems, are just as compelling – with First Nations experiencing lower employment, lower wages, lower education rates, and higher incarceration, among other socially derived determinants.

There are many complex interrelationships between health and social determinants which stymie simplistic interpretations. A Statistics Canada study showed that, while income and educational levels partially explained differences in health between Aboriginal and non-Aboriginal Canadians, disparities often persisted. Such findings point to the existence of other factors contributing to the greater burden of morbidity among First Nations, Métis and Inuit people. Furthermore, the factors often associated with health in the general population do not act in the same way among specific Aboriginal populations. The researchers proposed that further work examine broader, more culturally relevant predictors of health among Aboriginal people.[101]

Given that inequities exist and have complex underpinnings, what are the equity considerations of importance in a First Nations continuum of care? Is it *distributive justice* concerned with the achievement of equal outcomes across communities (First Nations and non-First Nations), such as in health status or community wellness, or is it *procedural justice* which ensures fairness of processes such as access to health and social services? In the short term, access to services may be the most practical equity to strive for, and, over

[100] https://www.who.int/topics/health_equity/en/

[101] Garner R, Varriere G, Sanmartin C. The health of First Nations living off-reserve, Inuit, and Metis adults in Canada: the impact of socioeconomic status on inequalities in health. 2010. http://www.statcan.gc.ca/pub/82-622-x/82-622-x2010004-eng.pdf

a longer time frame, health outcomes may be the preferred measure. In the interim, process indicators such as access to services and sufficient resourcing for these services can be used to forecast and predict outcomes.

The new child federal legislation concerning Indigenous child and family services enacted on January 1, 2020, has incorporated the term "substantive equality," which means that children and families must be treated in a manner which is substantively equal to other children and families – in other words, the treatment may be different, but the substance of outcome and supports are similar to other children and families in the same situation.[102]

In a resource constrained environment, an attempt to achieve the same magnitude of improvement across all facets of the continuum of care may mean adding so little to each area, that a strong impact cannot be achieved in any aspect of the health and social system. The length of time to achieve an impact may be a way to define how equity should be addressed; however, it brings other considerations. If, for example, access is limited by a notion that addressing injuries has a more immediate payback than addressing substance use, does that mean that a community in need of access to a substance abuse treatment facility is less deserving of resources than a community with a high injury and/or death rate due to vehicular accidents and drowning?

In the 7GCOC, a principle of equity is based on intersectoral health and social empowerment:

- utilizing leadership and processes to leverage intersectoral action across government departments to promote population health;
- involving the full extent of First Nations population groups (e.g. youth, adults, those with disabilities, elders, single parents, women, men, low income, urban, incarcerated, LGBTQIA+) in decisions and actions that identify, address and allocate resources to health needs;
- arranging health care financing and provision of services to be aligned with universal coverage, and redistribute resources towards groups with greater health care needs; and
- designing a comprehensive primary health care approach as a strategy that reinforces and integrates all other health equity promoting features. [103]

[102] Turpel-Lafond, M.E. 2019.

[103] Gilson, L et al. 2007. *Challenging Inequity Through Health Systems: Final Report Knowledge Network on Health Systems*. WHO Commission on the Social Determinants of Health.

Two-Eyed Seeing

A challenge of a contemporary 7GCOC is to combine the best of both worlds – First Nations ways of health and restoration of wellbeing through a focus on the entire individual and their environment, and mainstream health services' contributions of a medical model treating specific disease conditions and injury.

Two-Eyed Seeing is a guiding principle which bridges cultures introduced by Mi'kmaw Elder Albert Marshall in 2004. Two-eyed seeing refers to learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing ... and learning to use both these eyes together, for the benefit of all. Elder Albert indicates that Etuaptmumk - Two-Eyed Seeing is the gift of multiple perspective treasured by many Indigenous peoples. It is a foundational principle of collaboration between Indigenous and non-Indigenous worlds.[104]

Reciprocal Accountability

Reciprocal accountability is a shared responsibility amongst all parties to achieve common goals. Historically, accountability has been a one-way relationship from FNGs to various FPT governments for funds received. However, in today's environment of nation-to-nation relationships, and reconciliation between Indigenous and non-Indigenous societies, accountability in a health context has been expanded to include genuine collaboration where each party is responsible for their part of the health system, recognizing that the space occupied by each is interdependent and interconnected.

Reciprocal accountability can be further described as having:

- clear roles and responsibilities for all partners;
- clear performance expectations, with shared knowledge on agreed upon objectives, expected accomplishments, and constraints;
- balanced expectations based on the capacity of each party to deliver;
- credible and timely reporting of information on what has been achieved, whether the means used were appropriate and what has been learned;
- reasonable review and adjustment (annually) of performance by all parties, their achievements and difficulties, followed by appropriate corrective action; and
- an ethical foundation based on cultural teachings and best practices. [105]

[104] http://www.integrativescience.ca/Principles/TwoEyedSeeing/

[105] First Nations Health Council. Undated. *British Columbia Perspectives on a New Governance Arrangement: Consensus Paper.* First Nations Health Council: West Vancouver.

Designing a 7GCOC

The experiences of Indigenous integrated health systems in Canada have yielded some general observations of relevance when designing an 7GCOC:

- Integration, as a tool of a continuum, requires flexibility in designing First Nations/ federal/ provincial/territorial relationships and approaches;
- a prime objective a continuum is to facilitate the organization of the community health system around primary care, and provide direct linkages with the health care system outside of the boundaries of FNGs; in particular better communication mechanisms such as case management which bridges provincial and First Nations health care providers, or linkages with health and social service agencies which use a multi-disciplinary team approach to holistically meet the needs of their clients
- the health governance structure is segregated from the administration of health services. Accountability to communities is achieved through a community-appointed board, dialogue between communities and the health system's management, performance measures and/or annual community-based consultations;
- in northern areas of provinces, where First Nations people share primary care services with other residents, the most practical health systems are those which administer both federal and provincial services to all residents;
- devolving second and third level federal health services (such as nursing supervision or medical officer of health) to First Nations communities require multi-FNG partnerships in order to achieve the necessary economies of scale;
- alternative physician reimbursement mechanisms, such as salaries and contracts, facilitate integrated multi-disciplinary care focused on wholistic, population-based health programs;
- administration of basic health services by individual FNGs will promote capacity development and should be a moderating force in the move towards centralization which often accompanies the creation of a continuum;
- innovative models are required for FNGs which have small populations, and which cannot find workable partnership arrangements due to remoteness or other reasons; and
- the presence of multiple federal departments, each with their own multiple program funding arrangements presents opportunities for administrative cost efficiencies when integrated financial agreements are struck. Health systems gain flexibility and can design programs and allocate resources based on existing and emerging needs.[106]

[106] Lemchuk-Favel L and R Jock. 2004. A Framework for Aboriginal Health Systems. *Aboriginal Policy Research. Setting the Agenda for Change, Volume II*. Edited by J White, P Maxim and D Beavon. Toronto: Thompson Educational Publishing, Inc.

Challenges

Many of the challenges facing a 7GCOC have been alluded to in the section on characteristics and principles of a continuum – such has how to deal with the myriad of issues that directly impact access, support visionary leaders, build capacity, and ensure sustainability of the system. Even though many components of a First Nations health system may be in place, siloing of programs created through federal funding can mean separate administrations that discourage collaboration and increase cost. The consolidation of health information in a community is work in progress at best, and integration of provincial and FNG health information systems is still aspirational in most communities.

Provincial/territorial funding for primary care may be tied to an existing medical model – for example, funds may be used for physician services only, with the exception of the overhead component which might be more flexible and can be applied to other health professionals such as nurse practitioners. This can limit how FNGs may be able to use these funds for new initiatives.

Community members may be disinterested in taking charge of their own health such as through lifestyle changes, preferring to continue their association with a physician-led health system which is symptom-oriented.

Legislative barriers persist which prevent some traditional care, such as First Nation trained midwives, of operating independently of western oversight/models of care.

The challenges experienced by FNHA in setting up an integrated First Nations health system is informative, from the perspective of bringing multiple jurisdictions and over 200 communities together to achieve transformational change. They include:

- The transition process requires commitment and openness of partners, disciplined negotiations processes, established tripartite success factors, dedicated funding and robust briefing/communications/engagement processes. Transition can be long term, depending on the vision of the partners to the continuum, and at the FNHA, activities which are still in progress after six years of operation, include information technology system solutions, labour relations, and evolution of organizational design such as regionalization.

- There is an increasing demand on the FNHA as an organization and on FNGs to participate in a broad range of processes and tables at local, regional and provincial levels. Work is required on the relationship and alignment between all of the various components of the First Nations health governance structure – drawing clear linkages between the various components of the governance structure, particularly in terms of how issues, barriers and priorities can be resolved from local, regional, and provincial levels. Furthermore, there is a need to clarify roles and responsibilities, and define the right table and level to address issues, with a focus on distinguishing between political advocacy and operational tables and decisions.

- Racism in the system can be a persistent issue and partners need to move beyond training and education into initiatives that achieve systemic change.

- While there have been improvements, barriers to accessing health services remain, such as jurisdictional issues regarding service delivery in-community and away from home, and FNG territories straddling multiple health authority boundaries.

- Some funding and resources are short-term which creates challenges with sustainability of programming and services. There is a need to plan for and balance both organizational growth and investments at the provincial, regional and local/community levels to ensure long-term sustainability. [107]

Options

Interrelated strategies which underpin the continuum presented here include:

- an enabling environment is created, including information systems, educational support, and sustainable adequate resources;

- FNGs and individuals are engaged and empowered through a common vision and commitment by all partners, trust-based relationships, and shared decision making;

- governance and accountability are strengthened across the continuum at all levels from FNGs, health service organizations (HSOs), to regional and provincial entities; and

- services are coordinated within and across sectors.

Below, two options are presented for a 7GCOC; however, in reality, there are infinite variations as these choices represent opposite ends of a spectrum of approaches to building a continuum. These options, an essential continuum and an aspirational continuum, share many commonalities:

- The 7GCOC is built from community engagement to ensure that it is community-driven and community-based. Community wellness planning is undertaken across all programs areas, with support for organizational capacity development (personnel, information systems, data, and capital). The planning is needs based, uses First Nations and western knowledge, and reflects the circumstances of each particular community, rather than being a generic model.

[107] FNHA. 2019.

- CSH is embedded in all collaborations with partners. FNGs work with their provincial/territorial counterparts to develop mandatory courses for all facilities and programs that have a role in health and social care (from policy development to direct provision of services). Furthermore, joint work is undertaken with FPT partners to develop and administer workplans which will create an environment of CSH in the health and social system, for example, spaces within provincial facilities for ceremony and cultural practices such as for birthing.

- The scope of the continuum is broad, encompassing all First Nations, FPT funded health and health related services as well as social programs that have an impact on wellness, including justice, housing, education, social services among others.

- The continuum is organized around multi-disciplinary primary health care service delivery and administration, with a single entry point and case management. FNGs' community services provide a ready-made public health and/or primary health focal point from which to coordinate a larger sphere of services.

- The reach of the continuum's developmental activities is broad, drawing in all practitioners (both with and without the First Nations health system) to facilitate buy in and encourage staff retention. First Nations customs, which stress consensus and consultation, provide an opportunity for a system design strategy which is broadly inclusive of all health providers, and not physician centric.

- The catchment population in the continuum provides sufficient economies of scale, not only to achieve cost efficiencies in the day to day business, but also to create a buffer for unexpected demands, such as high needs clients whose care requirements might overwhelm an individual FNG's budget.

- Evaluation is not program specific, rather looks holistically at broad system change using culturally-based indicators that span the breadth of population health from cultural wellness to supportive systems (e.g. food security, acceptable housing, education) to indicators of physical, mental, spiritual and emotional wellness. [108]

- The initial emphasis of the continuum is on network building, rather than the need to 'own' the entire system, as this will allow greater flexibility, a quicker response to needs, build trust between organizations and allow organizations to identify services they provide versus those they obtain from partners. [109]

[108] First Nations Health Authority & BC Office of the Provincial Health Officer. 2020. *First Nations Population Health and Wellness Agenda. Summary of Findings.*

[109] Shortell et al. 1996. *Remaking Health Care in America: Building Organized Delivery Systems. San Francisco: Jossey-Bass Inc.*

The continuum spans multiple levels:

- integration of community services, with those which may still have federal administration (e.g. nursing stations) and provincial/territorial services directed to First Nations or Indigenous populations;
- integration of mainstream rural and urban health services with FNG health services;
- integration at the First Nations level among community health service and community sectors such as social services, housing and education; and
- integration between western community health services and traditional healing services.[110]

Organizational Design

The following figure shows a representation of the 7GCOC, with the individual, family and community at the centre, and care wrapped around, beginning with a primary care wellness team that is multi-disciplinary and seamlessly linked with allied health professionals who may be a distance from the primary care team, as well as speciality services, hospital care at all levels and long term care. The primary care team works collaboratively with public and population health providers who focus on wellness, health promotion and illness prevention.

Adapted from the Primary Health Care ++ model, BC FNHA. Source: FNHA, BC Ministry of Health and Indigenous Services Canada. 2019.
EHR: electronic health record; PT: physiotherapist; OT: occupational therapist; SLP: speech language pathologist.

[110] Maar M. 2004. "Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario." *Journal of Aboriginal Health.* 1 (1): 54-64.

Although this document is not focused on the care process itself, but rather the organization of services which will empower care, some general observations on priority care-based practices include:

- clients have continuity of care through attachment to a primary care professional. Attached persons have a lesser utilization of the emergency department and a lower rate of avoidable hospitalizations;[111]
- care planning involves clients, families and caregivers as substantive contributors to decisions on their care;
- effective care of people with complex needs is facilitated through case management;
- where possible, health providers are co-located, or if that is not possible, those external to the First Nations health system have links to resources within the community;
- the model of care is transformed to be strength-based, wholistic, and culturally safe;
- transitions between types of service providers, for example, from hospital to the home, are effectively managed;
- there is comprehensive care along the entire continuum, including response to crisis and urgent needs after hours, with ability to communicate and share information as required;
- technology supports the continuity and coordination of care, from basic information exchange to the ability to identify persons with multiple conditions or other complex needs; and
- ongoing capacity development to build skills, strengths and confidence of the workforce.[112]

Common Program and Service Elements of the Continuum

The following list is emblematic of the services provided throughout continuum, whether it be general primary care, mental wellness and addictions, chronic diseases, primary reproductive care (including prenatal programs, fatherhood programs, midwifery, birthing, post natal), maternal child health, oral health care, eye health, audiology, or other health needs serving the general population or specific sub groups, such as those with disabilities, elders, women, men, children and youth, LGBTQIA+, or those who are incarcerated or are caregivers. This is a vast list as might be expected from a wholistic approach to improving

[111] Lemchuk-Favel, L. 2019. *First Nations Data as a Support for Primary Care Innovation.* Presentation to the Canadian Public Health Association conference, April 30. Ottawa.

[112] WHO. 2018.

First Nations wellbeing which includes programs and services provided both by FNGs as well as other health system partners. A continuum of service provision may occur within the community, through mobile outreach programs, hub and spoke style program delivery, and also with partners who deliver specialized care and report back to community-based health providers.

- **Prevention:**
  - o illness and injury prevention programs; and
  - o health literacy and health promotion/education aimed at supporting people to manage their own health – programs include healthy lifestyle (e.g. diet and exercise), needle exchange, healthy eating, women's health, men's health, elder's health, parenting, smoking cessation, falls prevention, etc.
- **Screening:** early identification and intervention, for all diseases and conditions which are regularly screened in the mainstream health system
- **Primary health care:**
  - o at individual, family and community levels, addressing physical, mental, emotional and spiritual needs;
  - o behavioural and wholistic health focus;
  - o coordination of care and care planning: assessment, treatment, and follow up (includes detox and stabilization);
  - o counselling on pharmaceuticals/medications;
  - o can incorporate land-based camps, outpatient programs, residential treatment and youth healing, community based opioid therapy, stress/post traumatic stress disorder programs, among others;
  - o case management, family group conferencing, service coordination and referral; and
  - o support and aftercare: tailored to the individual
- Home and community care, including nursing, personal care, home making, rehabilitation and therapy services, respite care at a facility and in the home, adult day care, meal programs, mental health home-based services, and palliative care.

- Crisis response: community-based team; external supports for urgent needs.
- NIHB Program: pharmacy, medical supplies and equipment, dental, vision and medical transportation benefits which are managed by a First Nations organization at a regional or provincial level so that the client pool size is large enough for the program to be successfully administered.
- Telehealth and telemedicine.
- Secondary and tertiary care (e.g. specialists, hospitals): seamless link between primary care and specialized care, from assessment, through care planning to discharge planning. Liaison/links with hospitals and long-term care facilities.

- Public health services overseen by a medical officer of health, who administers a First Nations-created and directed communicable disease program.
- Traditional counseling and healing: seamlessly integrated into teams.
- Client advocacy services, for example, to assist as clients progress through the continuum.
- Food security: community gardens, community harvesting etc.
- Data and information: qualitative and quantitative data collection, access to provincially/territorially held data under the principles of OCAP®; electronic health information system (EHIS) which is linked to provincial health providers. Ultimately, a governance and administrative framework for implementation of an EHIS that is compatible with all service settings and protects client confidentiality.
- Linkages with health-related programs and services (e.g. SDOH):
    - o to support clients accessing housing, employment, education, social assistance and women's shelters and in navigating the justice system,
    - o advice for public health initiatives not within the mainstream primary health care, such as sanitation system construction and maintenance, disease surveillance, environmental health, food distribution
    - o collaborations with daycares, schools, child and family services, youth groups, prisons, employers/workplace programs.

A systems framework is useful for understanding the scope of change needed to implement a 7GCOC. Dr. Margo Greenwood has developed a three-level framework whereby the simultaneous alignment of actions across all three levels is necessary for long term and successful change. These levels are:

- **Service Delivery Change:** this relates primarily to mindsets at the individual level, such as instituting protocols for CSH, and the receptiveness of Western health professionals to embrace change.

- **Systemic Change:** at an organizational level, programs and services are modified, integrated, removed or enhanced.

- **Structural Change:** Accountability for these changes at the service delivery and systemic levels are embodied in legislation, policies and agreements. [113]

Service delivery change and systemic change are similar in both options. The difference lies in the degree of structural change – the size and degree of collaboration and formalization of agreements among all parties in the continuum. Option 1 assumes a regional scope of the continuum based upon administration of federally funded services with primary care contributions from other jurisdictions/partners, whereas in Option 2, full scale change is envisioned that would eventually result in FNG control over all aspects of health services to their populations via a fund holder model.

Option #1: Essential Continuum Model

This option focuses on the integration of services whereby a continuum is created through collaboration and networking of organizations without financial pooling of resources across multiple jurisdictions, tripartite agreements or legislation. Organizations which together provide a full continuum of care partner around common visions and goals, as well as more practical issues of client flow, care protocols and information systems.[114] This is the most common type of a care continuum now in evidence in Indigenous health systems, as FNGs develop protocols and understandings with neighbouring FNGs, non-Indigenous communities, health authorities, hospitals and private providers for defined services. FNGs may individually negotiate agreements with health authorities or the provincial/territorial government to secure funds that will assist with transformational aspects of developing the continuum, such as mobile mental wellness teams, contracting physician resources, hiring nurse practitioners, and filling gaps in services at the community level. Other agreements may provide the means for FNGs to access provincially held data on their populations, and jointly evaluate health status or institute public health programs of common concern to all parties (e.g. naloxone distribution, cancer screening etc.)

[113] Greenwood. M. 2017. *Determinants of Health and Indigenous People.* National Collaborating Centre for Aboriginal Health. Prince George: NCCAH. Presented at: International Meeting on Indigenous Child Health, March 31-April 2, 2017, Denver, Colorado.

[114] Leatt P, G Pink and M Guerriere. 2000. "Towards a Canadian Model of Integrated Care." *Healthcare Papers* 1, 2:13-35.

Option #2: Aspirational Continuum Model

The aspirational model is reflective of the vision of RCAP and the Romanow Commission where FNGs administer the majority of the services to their populations much like non-Indigenous health authorities in the provinces and territories. As health care is a provincial and territorial responsibility, and each of the thirteen jurisdictions have their own unique approaches to health care design and delivery at an organizational level, an aspirational 7GCOC will have the greatest impact and reach if it were designed in each jurisdiction independently, with enabling legislation, agreements, policies and protocols.

Formalizing Collaboration

This aspirational model will require a FPT level commitment whereby FNGs, provincial/territorial ministries, and the federal government work collaboratively in the design and delivery of all health services available to First Nations in their jurisdiction, and furthermore, that First Nations models of wellness are integrated into the health and social systems. There is no one size fits all approach to provincial/territorial collaboration. For example:

British Columbia

- In BC with the establishment of the FNHA and the collaborative processes which were developed in recognition that the provincial system provides the vast majority of health policy, funding, programs and service accessible to First Nations, a process of embedding First Nations priorities and perspectives into decision making processes or 'hard wiring' was developed. Examples of the effect of this hardwiring approach are the inclusion of the FNHA in the review of health authority mandate letters, First Nations representation on health authority boards, and joint planning and decision making in emergency situations and community crises. As well, the FNHA and Ministry of Health have annual letters of mutual accountability, which establish a set of expectations for partnership, engagement and priorities for action built upon the principle of reciprocal accountability.[115]

- First Nations communities in BC decided to remain separate from the provincial system, and FNHA operates under the *Societies Act* as a not for profit organization. Although this decision to remain outside of a legislated health system has retained First Nations autonomy as a distinct First Nations organization, this has come with limitations – as two examples, its Chief Medical Officer does not have provincial powers which are normally ascribed to provincial health officers, and access to First Nations health data is limited due to the different privacy legislation for public and

[115] FNHA, BC Ministry of Health and Indigenous Services Canada. 2019. Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance. West Vancouver: FNHA. https://www.fnha.ca/Documents/Evaluation-of-the-BC-Tripartite-Framework-Agreement-on-First-Nations-Health-Governance.pdf

private sector organizations. As well, First Nations' influence on the hospital system and physician services is achieved through advocacy and incremental change within the health authorities in defined areas, with supportive agreements that speak to collaboration and mandated First Nations involvement, such as the *Transformative Change Accord: First Nations Health Plan (2006) and BC Tripartite Framework Agreement* (2011).

- The *Health Partnership Accord* (2012) captured the vision of FNHA, BC and Government of Canada in developing a more responsive and integrated health system for First Nations in British Columbia. The partners to this agreement agreed to a vision which will ultimately lead to the incorporation of Indigenous models of wellness into the health system, better coordination of health planning and resources at all levels (community through to provincial) and better linkages between all levels, the implementation of a high quality, integrated system of community-based public health, primary care, home and community care and linked to culturally competent secondary and tertiary care, a province wide e-health strategy in First Nations communities fully integrated with the provincial e-health network, opportunities for shared services, and cultural competency throughout the entire system.

Quebec

- In Quebec, the CBHSSJB is a fully provincially recognized health authority board, with its own unique provincial legislation, and operates a full continuum of services within its borders including a hospital. The exception is some specialized care only found in tertiary level hospitals. Due to the terms of the JBNQA, most of the health funds relating to federal and provincial programs and services flow directly from the province.

Ontario

- In Ontario, the SLFNHA operates without separate provincial legislation for the entirety of its regional services; however, through a Sioux Lookout Four Party Hospital Services Agreement, the Sioux Lookout Meno Ya Win Health Centre (hospital) in Sioux Lookout, which serves the First Nations and non-First Nations population, was established and operates under the Public Hospitals Act as a facility fully funded by the Province of Ontario. It was incorporated under a special Act of the Ontario Legislature. The inaugural Board was comprised of 10 members appointed by First Nations, five members appointed by the southern communities, two doctors and a First Nations traditional healer. [116]

[116] http://www.slmhc.on.ca/hospital-services-agreement

Federal Legislation

Transformational change of the health system, such as the 7GCOC herein described, is a stated goal of First Nations. In the voices of Chiefs-in-Assembly, this change must be from sickness-based models to First Nations-led systems based in their cultures and through a social determinants of health approach; from a disregard of First Nations rights, jurisdiction and priorities to respectful and mutual partnerships; and from chronic underfunding to sustainable, long-term investment from federal, provincial and territorial health systems. The mechanism to achieve this transformation will require legislative acknowledgement of First Nations controlled health systems.

A legislative basis for First Nations health will be instrumental in discussions with provinces and territories on their partnerships with, and contributions to, a 7GCOC. Through "Resolution 69/2017 Exploring a Legislative Base for First Nations Health" AFN has been directed to examine options related to federal First Nations health legislation that would articulate federal obligations towards First Nations health, reflective of inherent, Treaty and international legal obligations, as well as the nation-to-nation relationship. This resolution has mandated AFN to develop tools to aid interested First Nations communities in developing their own positions related to federal legislation on First Nations health.

The Canadian Government's 2019 Speech from the Throne has validated this direction by including a commitment to 'co-develop new legislation to ensure that Indigenous people have access to high-quality, culturally relevant health care and mental health services.' This commitment has been reinforced in the Mandate Letter to the Minister of Indigenous Services. In this mandate letter, the importance that Canada places on a wholistic approach to health and well-being of First Nations was highlighted, including work to implement UNDRIP, ostensibly through the renewed relationship between the Crown and First Nations involving a new level of engagement on all legislative, policy, program and planning initiatives being undertaken by the federal government. First Nations participation in health policy initiatives and existing program mechanisms must be on the basis of the recognition of First Nations inherent and Treaty rights affirmed and protected under Section 35 of the Constitution Act, 1982, and take into account international law and First Nations inherent and Treaty right to trade with and between nations in North America and globally. The mandate letter goes on to state:

- "As Minister of Indigenous Services, you will work to ensure a consistent, high-quality and distinctions-based approach to the delivery of services to Indigenous Peoples. In parallel, you will work with the Minister of Crown-Indigenous Relations on capacity building to bring control of and jurisdiction for service delivery back to Indigenous communities."

- "Co-develop distinctions-based Indigenous health legislation, backed with the investments needed to deliver high-quality health care for all Indigenous Peoples."

- "Continue to work with First Nations communities to ensure First Nations control over the development and delivery of services."

Funding

The mechanism of funding is another feature of an aspirational model which involves First Nations involvement in health services that encompass those under FNG, federal, provincial/territorial jurisdictions. Again, there are various approaches. Flexible and consolidated funding was an important recommendation of both RCAP and the Romanow Commissions. Although much of this momentum for change was lost when the newly elected federal government did not carry through with the Kelowna Accord,[117] the concept of block or pooled funding did survive and has been expressed in tripartite health agreements, such as the province wide *Tripartite First Nations Health Plan* in British Columbia. The FNHA's model is outside of the governing structure of the provincial health system and provincial funding is negotiated separately on a case by case basis according to mutually agreed upon priorities. The most ambitious co funding agreement to date is the plan to establish seventeen First Nations primary care centres throughout out the province. Federal funds for existing programs are provided through a five-year Canada Funding Agreement, and new funding is provided through a supplemental agreement.

With the CBHSSJB, the board receives funding for all health services within its boundaries from the province, including hospital and physician care, and federal funds previously directly administered to communities before the JBNQA. The SLFNHA has much the same arrangement for provincial hospital and physician services, although the federal component has remained separate and is not administered by the province of Ontario.

As the FNHA is province-wide, a geographic-based funding approach such as the James Bay Cree and Sioux Lookout which each cover a primarily First Nations populated remote area with agreements to provide services to the entire population, would have required a fundamental realignment of the health system as advocated by the Romanow Commission through capitation funding for provincial/territorial services, which would provide a solution for First Nations across large geographies primarily populated with non-First Nations. Capitation financing provides a set amount of money per enrollee and generally use a formula which at a minimum, adjusts for the age and sex of the rostered population, and geographic variability in the cost of health goods and services. Other adjusters are population-specific, and for the First Nations population, could include utilization and/or prevalence rates of the most prevalent chronic conditions, functional disabilities, mental disor-

[117] The Kelowna Accord (2005) was a series of agreements between the Government of Canada, First Ministers of the Provinces, Territorial Leaders, and the leaders of five national Aboriginal organizations in Canada. The accord sought to improve the education, employment, and living conditions for Aboriginal peoples through governmental funding and other programs.

ders/suicides or other community relevant health and social indicators. Although funds may be identified with different sources, First Nations organizations would have the flexibility to allocate resources in response to new or emerging health priorities.

As budget holders, the First Nations HSOs would purchase services for their enrolled members. This could be extended to community members who live off reserve, as these HSOs could have capitation-based contracts with physicians to provide primary care to people enrolled in their organization. Similarly, funds could be held for secondary and tertiary care, whereby First Nations HSOs contract with specialists, hospitals and other providers on a performance contract basis. Such an arrangement would likely require statutory obligations of these provincially/territorially funded providers to enter into such arrangements, such as what is seen in New Zealand with Maori health entities who serve this essential role, and where they have been credited with reducing access barriers an improving the effectiveness and appropriateness of services to Maori.[118]

The AFN Health Transformation Agenda presented a cost analysis of new federal investments in all program areas, including the costs of updating the present funding formula with accurate populations (back to 1999), a new escalator and infrastructure investments, corporate operations and governance & engagement. This list is comprehensive from the federal programming perspective and totalled $1.6 billion in 2017 dollars; however, it should be re examined in light of the partnerships being required with provincial and territorial governments, and the type of additional investments sought from these jurisdictions (an example could be the development of primary health care teams and centres) including the considerable costs related to being meaningful participants in their health and social systems at all levels, from health authorities to provincial/territorial ministries.

Policy Shifts

A fully functional 7GCOC will optimally benefit from policy improvements within federal and provincial/territorial jurisdictions that are centred on a strength-based vision of wellness, allow for a full expression of traditional healing approaches, and build First Nations capacity to assume a greater role in the health system. Examples of policy areas requiring transformational change are:

- There are a variety of approaches to traditional midwifery across the provinces and territories with no unifying federal policy which would apply to First Nations midwives. Such a policy could aid in the removal of legislative barriers which prevent some traditional care, such as First Nation trained midwives, of operating independently of western oversight/models of care.

[118] Ministry of Health. 2001. *He Korowai Oranga: Maori Health Strategy Discussion* Document. Wellington: Government of New Zealand.

- Traditional healing is not formally integrated into federally funded programs such as mental wellness and home and community care. Such a recognition would facilitate adequate funds to be received for employment of these specialists. Similarly, work is required with provinces and territories to include traditional knowledge and healing modalities into their health systems.

- Lack of wage parity in First Nations health systems is a significant long-standing issue. A 7GCOC requires the ability to competitively compete for health professionals based on receiving program funds that include salary considerations which are equal to what similar professionals make in FPT administered programs. Using traditional healing as an example, First Nations healers, when paid, receive a fraction of what western health professionals are remunerated. Even with recognized health professions such as nursing, the FPT jurisdictions clearly have the upper hand, with an ability to meet collective agreement requirements of salaries and overtime from their general tax coffers when necessary, whereas FNGs have no such recourse.

- An expanded definition of a health care professional in First Nations health systems is required that would include health and social service providers who have no counterpart in the FPT systems, such as wellness workers, community health representatives and traditional healers.

- A multi-ministry shift is required at all levels and across all sectors, to fully embody the determinants of health as a pivotal strategy to wellness that begins with the individual, and is strength based. This includes a recognition that there are new stressors that may have not been classified as determinants of health to date, such as climate change and its impact on food availability, mental health, chronic disease and housing.

- Recognition of First Nations data governance will require facilitating legislation where necessary to allow First Nations HSOs to receive needed data on their populations from data holders, such as health authorities, provincial/territorial ministries of health, education, justice, family and social services among others.

- The AFN and Indigenous Services Canada are collaborating on a Joint Review of the NIHB Program. This review is focused on improving access to the NIHB Program benefit coverage and associated efficiencies in all areas of the Program. Policy recommendations from this review should be reviewed from the lens of the needs of a 7GCOC.

Concluding Comments

This review of the literature as documented in this report has put forward the case for a 7GCOC which is accessible across all dimensions, built around the person, individual and community, has First Nations governance, is collaborative and integrated into the broader health care system, is wholistic and culturally safe, embeds traditional medicine as an integral aspect of care, is sustainable, and has the data and information needed to effectively manage and evaluate services. It is based on the principles of leaving no one behind, the ancestral teachings of the seven grandfathers, reconciliation with Canadian society, provision of close to home services, CSH, and equity and reciprocal accountability with the mainstream health system. The knowledge system is a blend of the First Nations world view and western scientific contributions to healing through the concept of two-eyed seeing. Its foundation is self-determination of First Nations, powered by strong engagement with all FNGs and their members.

How will First Nations know when a 7GCOC has been achieved? Certainly, the geopolitical and cultural diversity of First Nations across the breadth of Canada suggest that continuum of care models may be equally as diverse. Even so, there are a number of signposts that will demonstrate an operational continuum of care from the client's perspective:

- Clients from all walks of life and degrees of ability feel welcome, comfortable and safe at their appointments, which are reflected through measures of satisfaction. They have ready access to primary care in their home community.
- Clients have the choice of traditional healing services which are seamlessly integrated into care teams.
- Clients have better alternatives to emergency room visits for non-urgent needs.
- Clients don't have to wait at one level of care (e.g. hospitals) because of services are not available at another level of care (e.g. home care).
- Clients can make an appointment for a visit to a clinician, a diagnostic test, or a treatment with one phone call.
- Clients have a choice of primary care providers who are able to give them the time they need, and care is organized through a multi-disciplinary team.
- Clients don't have to repeat their health history each time they see a new health provider.

- Clients don't have to undergo the same test multiple times for different providers; their health-care provider will have been informed that they have been hospitalized, undergone treatment procedures, referred to other providers, or received prescriptions. Clients receive easy to-understand information about quality of care and clinical outcomes in order to make informed choices about providers and treatment options.

- Clients have 24-hour access to a primary care provider. With chronic disease, they are routinely contacted to have tests that identify problems before they occur, provided with education about their disease process and how to care for themselves, and have in home support when necessary.

The two options advanced in this report represent opposite ends of a spectrum of approaches to building a 7GCOC. In practical terms, an operational continuum may be at various points along this range whereby individual FNG jurisdictions each design a system which is responsive to their own environment and needs. Alternatively, the first option may represent a starting point, from which a more nuanced and elaborate continuum can be designed over time.