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# Implementing Indigenous community control in health care: lessons from Canada

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## Abstract

**Objective.** Over past decades, Australian and Canadian Indigenous primary healthcare policies have focused on supporting community controlled Indigenous health organisations. After more than 20 years of sustained effort, over 89% of eligible communities in Canada are currently engaged in the planning, management and provision of community controlled health services. In Australia, policy commitment to community control has also been in place for more than 25 years, but implementation has been complicated by unrealistic timelines, underdeveloped change management processes, inflexible funding agreements and distrust. This paper discusses the lessons from the Canadian experience to inform the continuing efforts to achieve the implementation of community control in Australia.

**Methods.** We reviewed Canadian policy and evaluation grey literature documents, and assessed lessons and recommendations for relevance to the Australian context.

**Results.** Our analysis yielded three broad lessons. First, implementing community control takes time. It took Canada 20 years to achieve 89% implementation. To succeed, Australia will need to make a firm long term commitment to this objective. Second, implementing community control is complex. Communities require adequate resources to support change management. And third, accountability frameworks must be tailored to the Indigenous primary health care context to be meaningful.

**Conclusions.** We conclude that although the Canadian experience is based on a different context, the processes and tools created to implement community control in Canada can help inform the Australian context.

**What is known about the topic?** Although Australia has promoted Indigenous control over primary healthcare (PHC) services, implementation remains incomplete. Enduring barriers to the transfer of PHC services to community control have not been addressed in the largely sporadic attention to this challenge to date, despite significant recent efforts in some jurisdictions.

**What does this paper add?** The Canadian experience indicates that transferring PHC from government to community ownership requires sustained commitment, adequate resourcing of the change process and the development of a meaningful accountability framework tailored to the sector.

**What are the implications for practitioners?** Policy makers in Australia will need to attend to reform in contractual arrangements (towards pooled or bundled funding), adopt a long-term vision for transfer and find ways to harmonise the roles of federal and state governments. The arrangements achieved in some communities in the Australian Coordinated Care Trials (and still in place) provide a model.

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## Introduction

Internationally, primary healthcare (PHC)[1] renewal continues to be identified as a key pathway to achieving health equity, meeting the needs of underserved and poorly served populations, and for improving the efficiency of healthcare systems.[2–4] PHC services generally include four key components: (1) primary care provided by general practitioners (GPs) and, more recently, by nurse practitioners; (2) primary prevention activities (health promotion) designed to prevent the onset of illness; (3) secondary prevention interventions focused on assisting in the management of chronic illness to avoid or delay the development of complications; and (4) tertiary prevention interventions designed to assist in the management of complications, to ensure that optimal autonomy is retained. Advocacy and referrals are integral

components.[1] Comprehensive PHC, the goal of Indigenous providers of health care (and some others), also emphasises the need to attend to and be informed by the social determinants of health that affect the health and life chances of the people, and their access to good health care. In this paper, the focus is on the provision of comprehensive PHC by Indigenous community-based organisations.

Evidence shows that when PHC is not accessible (geographically, economically or culturally), responsive or effective, people delay seeking help, rely on emergency care and lose the benefits of continuity of care.[2,5] In many countries, histories of colonialism have resulted in power differentials that negatively affect PHC access and responsiveness to Indigenous people's needs. For the past 25 years, both Canada and Australia have endorsed community control of Indigenous health services, but implementation has followed different pathways. Canada has focused on transferring pre-existing PHC services previously delivered by the federal government to the established First Nations local government authorities 'on reserves' (i.e. for discrete First Nations communities). In the Canadian context, community control over these services has been constrained by a disconnect between resourcing and needs, as well as some contractual inflexibilities, which, at times, undermine responsiveness.[6,7] Australia has established a multiplicity of Commonwealth, state and territory funding programs for community-controlled PHC[8] in response to community activism in the 1970s. The Aboriginal Community Controlled Health Organisation (ACCHO) sector has grown substantially over the past 40 years, largely through the funding of community-initiated submissions. In the Australian context, community-controlled PHC has been constrained by an over-reliance on short-term specific-purpose funding and inflexible contractual obligations.[9] More recently, some jurisdictions have been promoting the transfer of PHC services delivered in Aboriginal communities from the state or territory health authority to an Aboriginal community-based governance structure. However, the process in both countries has been bumpy and complex.

Policies in favour of Indigenous community control clearly face implementation challenges in both countries. The aim of the present paper is to contribute to continuing efforts to achieve implementation, with a particular focus on how the Canadian experience could inform Australian implementation approaches.

## Methods

Canadian challenges and strategies were reviewed, with reference to policy and evaluation documents (grey literature) that emerged over time. The Canadian strategies were then assessed for relevance to the Australian context, recognising the common complexities of implementing community control across communities with diverse needs, capacities and experience, the challenges of formulating a meaningful accountability framework and the need for adaptation of administrative arrangements to support the delivery of responsive PHC.

## Results and Discussion

In Canada, provincial governments have constitutional responsibility for the planning and delivery of healthcare services. The federal government started to assume responsibility for the delivery of health services on-reserve in the 1920s,[10] on humanitarian grounds (so federal policy states) or based on Treaty obligations (according to First Nations; for a more detailed discussion, see Boyer[11]). By the mid-1960s, most of the 610 First Nation reserve communities had access to some level of public health and PHC services delivered by federally employed nurses and interpreters. Community Health Representatives (CHRs; the Canadian equivalent of Aboriginal Health Workers) were added to the team in the mid-1970s, along with Addiction Prevention Workers (APWs). The role of the CHRs was to assist nurses with prevention and treatment activities. CHRs and APWs were employed by the community, with funding from the federal government. This was the beginning of community control.

CHRs and APWs were employed in nearly all First Nation communities; only very small communities were not provided with this opportunity. CHRs and APWs were hired by Chief and Council, the governance structure originally created by the Indian Act in 1876.[12] The Chief and Council governance structure is the equivalent of local government, and continues to be the point of contact for consultation, negotiations and, in some cases, joint decision making with other levels of government (municipal, regional, provincial or federal). Chief and Council can also, if the community wishes, exercise some control over community-based schools, health services, child protection, economic development, community infrastructure and other federally funded programs.[13]

In 1985, a change was made to the Canadian Constitution (Section 35) recognising the right of First Nations, Inuit and Métis' to self-government. Greater opportunities for community control emerged as a result. Funding options include multidepartment funding agreements (MDFA), block funding agreements (BFA) and flexible funding agreements (FFA). Flexibility depends on the model chosen by the community. MDFAs are the most flexible because they bring together multiple social programs, such as health, education, child welfare, economic development, income assistance, infrastructure, housing and local governance, under a single relational agreement. In contrast, BFAs and FFAs relate to health services only. BFAs are block-funded flexible agreements signed for 3–5 years. A new version of this option is being offered, allowing communities to sign for up to 10 years, with opportunities to add new programs as they emerge. In contrast, communities that sign an FFA must instead secure the federal government's permission before moving funding between budgetary lines.[14] These options have been relatively well received by First Nations, with 89% of the eligible 610 First Nation communities involved in one or other type of agreement as of 2008.[15] Communities who are not interested or ready to engage in this process (because of a perceived lack of capacity or other priorities) continue to receive their community-based PHC from federal government employees.

Pre-existing services delivered by the First Nations and Inuit Health Branch of Health Canada (FNIHB; the Canadian equivalent of the Office of Aboriginal and Torres Strait Islander Health (OATSIH)) are being transferred to community control. Communities wanting to manage on-reserve health services simply express this interest to the federal government. Unless the community has a history of management challenges with other

programs, the federal government extends bridge funding for 12 months for the community to undertake a community needs assessment and develop a community health plan.[16] Funding for community health services is based on historical expenditures in that community, and this is for the most part non-negotiable.[6] Once the community health plan has been approved by the federal government, community control can be implemented. Communities can choose to sign an agreement alone or as part of a multicommunity consortium. Communities of less than 500 members are precluded from signing a BFA unless they affiliate themselves with other communities because of sustainability issues. Communities receive separate funding to undertake an evaluation of their services every 5 years. Recent work has demonstrated that First Nation-controlled services are able to deliver on health outcomes.[17]

### The accountability struggle

Canada has struggled with issues of accountability. When community control was initially implemented, agreements included onerous reporting requirements. Local FNIHB program managers adopted pragmatic strategies to ease that burden by overlooking missing reports of little utility.[7] In 1997, the Auditor General of Canada chastised FNIHB for not following up on missing reports.[18] From then on, punitive measures (withholding of funding) were put in place to ensure that all reporting requirements were met.[19] In 2004, the Auditor General of Canada revisited First Nations' reporting requirements, suggesting that, in fact, these were unduly onerous, dictated by government funders rather than based on consultations, of low use for community organisations, incremental because new programs added reports without considering the overall reporting burden, failed to inform on performance and were largely unused to report to Parliament.[20]

The Auditor General of Canada further pointed out that 'there's not much point in First Nations exchanging data for dollars with the federal government when the information is of no real benefit to either party'.[21] Lavoie *et al.*[7] documented that in 2003–04, First Nations in the province of British Columbia (169 communities) produced an estimated 5813 reports to meet their accountability requirements for health services alone. They further noted that many reports were never read because FNIHB lacked the human resources to do so. First Nations and FNIHB confirmed having little use for the information collected.

A key barrier to consolidating a meaningful reporting framework has been the accountability requirements of Treasury Board of Canada Secretariat (hereafter Treasury Board), which oversees accountability for all federal programs, grants and contribution agreements. In 2006, an independent Blue Ribbon Panel appointed by the Treasury Board reviewed all grants and contributions ($27 billion CND in annual spending), including those discussed herein. They concluded that:

(1) There is a need for fundamental change in the way the federal government understands, designs, manages and accounts for its grant and contribution programs.
(2) Not only is it possible to simplify administration while strengthening accountability, but it is absolutely necessary to do the first in order to ensure the latter.
(3) Making changes in an area of government as vast and multifaceted as grants and contributions will require sustained leadership at the political and public service levels.[22]

To operationalise these, the Blue Ribbon Panel recommended the following.

(1) Increased respect for recipients of grants and contribution agreements, and the reframing of this relationship as a partnership.
(2) A marked simplification of the reporting and accountability regimen to reflect the circumstances and capacities of recipients and the real information needs of the federal government.
(3) Encouraging innovation, stating that 'the goal of grants and contribution programs is not to eliminate errors but to achieve results, and that requires a sensible regime of risk management and performance reporting'.[22]
(4) Organising information collected so that it can serve program managers and recipients alike.

The panel noted that mechanisms other than grants or contributions are needed for the funding of essential services such as health, education and social assistance in First Nation communities because grants and contribution agreements lead to costly and unnecessary reporting burden.

The report of the Blue Ribbon Panel led to the revisions in the contribution agreements used by FNIHB discussed above. FNIHB was also tasked to consolidate reporting requirements and reduce the burden. A first iteration was produced in 2008.[23,24] Another revision is underway, in consultation with First Nations provincial organisations (peak bodies for communities), to further reduce onerous requirements and include key outcome indicators developed by FNIHB.[25]

### Lessons for Australia?

The Canadian context is very different from the Australian one. Importantly, there are no equivalents to the treaties and the Royal Proclamation of 1763 that recognised continuing Indigenous rights in Canada. Aboriginal and Torres Strait Islander peoples are not recognised in the Australian Constitution and government responsibility for Indigenous health is not defined in health law.[26] Thus, there is no enduring basis for accountability by governments for improvements in Aboriginal health care, including for transferring PHC provision to community-controlled healthcare providers, despite continuing policy commitments.[26,27] Further, despite earlier policy commitments to self-determination,[28] the policy discourse has largely shifted away from Indigenous rights and towards a focus on 'closing the gap' in social, economic and health status indicators between Indigenous and non-Indigenous Australians.[29]

Second, First Nations are taking on pre-existing services, previously delivered by the federal government in discrete communities, whereas this is not usually the case in Australia, where community-controlled services have more often been created *de novo*. When taking on community control, the responsibility for the management and delivery of services is transferred to a pre-existing governance structure that has been regulated by a federal act of parliament since 1876. In contrast, Australian community-controlled health services are non-government organisations

owned by the local community and incorporated under various national or state laws.

Finally, BFAs and FFAs are transfers from a single level of government. MDFAs, when associated with land claim agreements, can be tripartite agreements between the federal department in charge of First Nation health, the Ministry in charge of First Nation education, economic development, income assistance, governance etc. and the First Nation. For example, the Nisga'a Agreement, the James Bay and Northern Quebec Agreement, and the Labrador Inuit Association Agreement are legislated tripartite agreements that include provisions for self-administration of health services.[30] Accountability provisions for MDFA agreements sit outside the usual grant and contribution agreement frameworks, and provide First Nations who are signatories with budgetary line flexibility across healthcare, income assistance, economic developments and other spheres of government funding. These agreements can facilitate cross-sectoral innovations focused on determinants of health. There is no equivalent in Australia (Table 1).

Given these important differences, what then can be learned from such a different context?

### *Lesson 1: implementing community control takes time*

As shown in Fig. 1, implementing community control in Canada to the 89% level took 20 years (1989–2008),[15] despite the fact that community control was being implemented in communities with considerable engagement with the community-based healthcare services and a governance structure that had been in place since 1876. In Australia, efforts to transfer services to community control are generally conducted under tight timelines,[31] which are generally not achieved, leaving a sense of failure and opportunities for allocating blame.[32]

**Table 1. Comparison of contexts and processes for implementing community control in Canada and Australia**

| | Canada | Australia |
|---|---|---|
| Pre-existing health services are being transferred | Yes | Local services often created *de novo*; some transfers from state governments |
| Transfer is to a pre-existing Indigenous governance structure that manages other programs as well | Yes | No; some health services established by existing community organisations |
| Single government (federal) to single government (First Nation) transfer | Self-government agreements can be tripartite; others are single government transfers | No; transfer requires tripartite agreements |

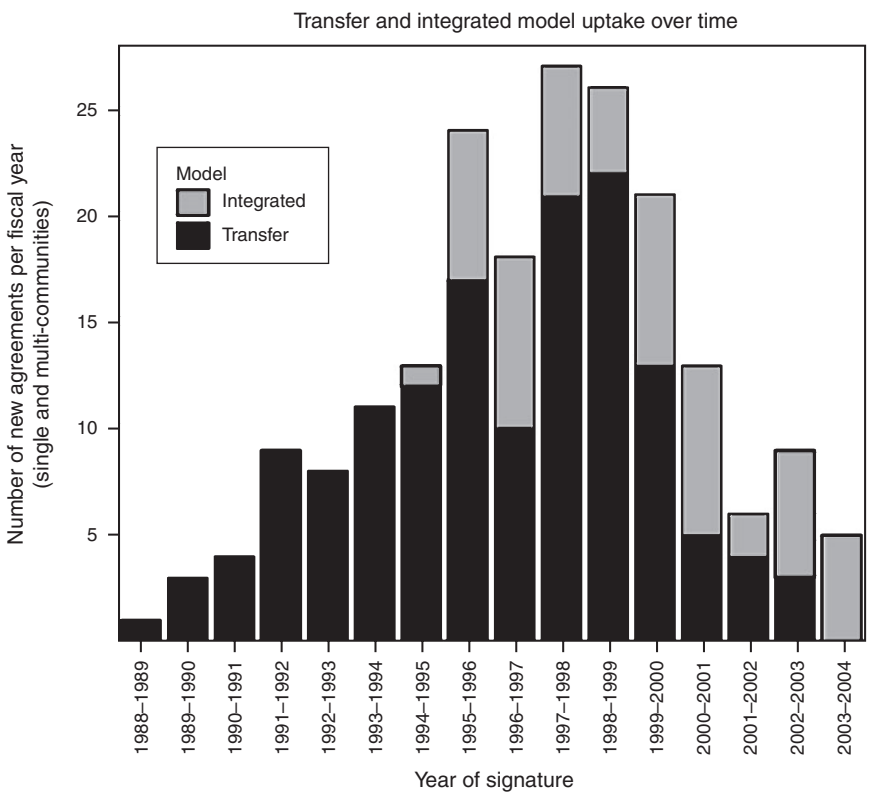


**Fig. 1.** Community control uptake in Canada over time: Transfer and integrated models.

### Lesson 2: supporting change management with resources

As discussed above, the federal government initially funds First Nations for 12 months to develop a community health plan that reflects community-identified priorities. Every 5 years, the same organisations receive funding to undertake an evaluation of their services, which is used to adjust the community health plan before renewal. Research suggests that this change management cycle is key to ensuring continuous improvement.[7]

### Lesson 3: tackling the thorny issue of accountability

Canada is slowly developing tailored mechanisms designed to fund First Nation health organisations. Accountability frameworks based on meaningful indicators are attached to the funding mechanisms. Although the work is far from complete, tailored administrative instruments are more likely to yield meaningful information that can be used by federal and First Nation program managers to ensure that services deliver on their objectives.

This work needs to happen in Australia as well, but there are significant barriers. The problems of low levels of trust across cultures, and the continuing effects of histories of dispossession and conflict are important factors. However, they are common to both countries. We suggest that there are three major barriers that differentially affect approaches to the implementation of community control in Australia.

*Current contractual arrangements are ill-equipped to deliver PHC outcomes* The first barrier stems from the fact that Australia embraced the contractual approaches of new public management (NPM) more thoroughly than Canada,[33] which means that moving to an approach that meets the needs of PHC is more difficult. Evidence shows that over-reliance on NPM-informed contractual agreements is unhelpful to local governance in rural and remote Indigenous communities.[34] In funding PHC, this approach, with its focus on tendering predefined specific health interventions, has also been found to be a poor fit[9,35] because PHC requires continuity of care and long-term trust-based relationships between healthcare providers and clients. A model for such a funding arrangement exists in the agreement still in place for Katherine West Health Board in the Northern Territory (a funds-pooling arrangement originally established as part of the Coordinated Care Trials[36]).

*Implementing sustainable and effective community control in Australia will take time, and success requires a long-term vision and resources for change* In many rural and remote Australian Aboriginal communities, where the jurisdictional health authority provides basic primary care, transfer to community control will require careful community processes of development and agreement making in order to establish a structure and plan for local or regional ownership and delivery of PHC. This needs to be supported in policy and guidelines, resourced and factored into timelines. So far, and in the context of the legacy of dispossession and community dislocation, Australian governments have underestimated the amount of work and time required.[32] Political commitment that endures beyond election cycles is also needed.

*Accountability on both sides* The more complex mix of funding and regulatory roles between levels of government in Australia means that no government holds enduring responsibility for Aboriginal and Torres Strait Islander health, and thus no government holds clear accountability for improvement.[26] Although constitutional reform may be required to fully address this issue, other solutions include: (1) the allocation of responsibility for PHC to the federal government, as recommended by the National Health and Hospital Reform Commission;[37] or (2) federal and state agreements enacted in matching legislation, clarifying roles and responsibilities and harmonising contractual and accountability requirements.[26]

Recognition that administrative simplification is necessary in order to strengthen accountability, as articulated in the Blue Ribbon Panel report to the Canadian Treasury Board,[22] could provide the basis for the reform of approaches to funding contracts in Australia. The development of a national system of meaningful indicators of health care effectiveness in PHC for Aboriginal people[38] is an important step in that direction.

Accountability by ACCHOs to their communities is structured into the sector by community ownership, but enactment and reporting of that accountability (for quality and access, good governance and responsiveness to community priorities) is less visible. The sector is actively working on methods to address this requirement (see http://www.naccho.org.au/promote-health/governance-initiative/, accessed 4 September 2015).

## Conclusions

Current efforts to facilitate the development of the community-controlled sector in Australia stand to make a unique contribution to closing the gap in Aboriginal and Torres Strait Islander health. Canada has been engaged in a similar process for over 20 years, and the available evidence indicates that the gap can be narrowed with effective community-controlled PHC.[17]

The Canadian context is different, and we do not believe Canadian solutions will fit the Australian context exactly. Still, Canada's experience can inform the implementation of community control in Australia.

## Competing interests

None declared.

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