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# Is There Self-Determination in Canada's First Nations Communities?

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**ABSTRACT** What is self-determination? How was the definition created? Examining First Nations health care systems has shown that definitions of self-determination for First Nations leaders and communities are different from those provided by federal and provincial governments. To ensure First Nations survival in the long term, it is important for First Nations people, leaders and communities to collaboratively develop definitions of self-determination in an Aboriginal context. This paper reviews perceptions of self-determination in health care by First Nations, and provincial and federal governments, and how relationships between these three groups are affected by differing perceptions. The impacts of colonialism are examined and discussed as they pertain to perceptions of self-determination in health care in First Nations communities. To survive, First Nations must establish firm definitions and boundaries to prevent further oppression and colonization, and to navigate control of their health and health care for future generations.

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**KEYWORDS** Aboriginal people, First Nations people, First Nations health care, Health Care—Canada, health policy

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## Introduction

All people living in a democracy are believed to have self-determination over their lives; which is the power of choice in all aspects of their lives (Buchan 2003; Royal Commission on Aboriginal Peoples 1996a). There is considerable literature that discusses self-determination in Aboriginal communities in Canada, but not necessarily in health (Borrows 2001; Boyer 2003: 2; Royal Commission on Aboriginal Peoples 1996b). However, after examining First Nations health care systems in four First Nations communities in Canada, it is apparent that the definition of self-determination is different for First Nations leaders and people than for bureaucrats in federal and provincial governments. The definition of self-determination currently used by the federal government with regards to health leans toward administrative or bureaucratic control of health programs and services decisions in First Nations communities rather than true choice for an individual or community's health and the primary health care they receive (Borrows 2001; Buchan 2003; Napoleon 2005). With a lack of health care options in many First Nations communities, First Nations people do not have true choice over their health care (i.e., when, where, and who provides their health care to them). Therefore, it is important for First Nations people, their leaders and their communities to work collaboratively to establish a clear and concise definition of self-determination in health and health care that will be used when dealing with the federal and provincial governments, who often provide funding and resources.

Through the enactment of the "British North America Act," "Indians" became wards of the state with limited rights and freedoms (Borrows 1994; Miller 1990). Many other policies and legislations, such as the Indian Act of 1876 and the White Paper of 1969, have created tension in the relationship between Aboriginal people and the federal government. Due to this tension and the First Nations (the current term used for "Indians") belief that they have an inherent right of sovereignty, they continue to strive for self-determination with the freedom to choose how to express "their identity, their sense of themselves and the character of their relations with others" (Royal Commission on Aboriginal Peoples 1996b: 108). Returning to being self-determining and self-governing will assist with revitalizing and reclaiming their cultural identity, which has been shown to be a protective factor for health (Chandler & Lalonde 1998; Warry 1998; Warry 2007). Therefore reclaiming cultural identity can assist First Nations people, and communities may promote self-determination in their health care systems and may ultimately improve their health.

Taking control of health care could be a first step toward decolonization and reconciliation from the oppressive and colonial policies of the past two

hundred years in First Nations health care. In Canada, the federal government has sent mixed messages about self-determination. Through the Indian Act and residential schools, First Nations people were legally unable to use traditional healing practices and discouraged from the use of traditional medicines. Intergenerational trauma and the inequitable relationship between First Nations and the federal government has led to gaps in the health care available and provided to First Nations people who remain on reserves in their traditional territories (Loppie & Wien 2009). Thus to obtain *choice* in health care (to be considered biomedical), a First Nations person or family must leave their reserve and community and enter the provincially run health care systems that are secular and often blind to First Nations socio-political history with the nation-state that has led to a myriad of health conditions that were not present at contact or shortly thereafter.

Self-determination in health may hold the key to providing culturally sensitive health services to match evolving health care needs of First Nations communities. This self-determination in health care may be the catalyst that could promote self-governance in other aspects of First Nations communities such as education, community development, cultural traditions and policy development (Graham & Wilson 2004).

Some scholars (Lavoie 2011; Romanow 2002; Royal Commission on Aboriginal Peoples 1996c) stress that certain factors are required for self-determining First Nations health care systems, such as strong and open communications, adequate funding, and leadership capacity. Health Canada (2004) and First Nations Healing (2010) state that these factors can move First Nations communities toward an ideal First Nations health care system that is culturally and linguistically responsive and provides communities with increasing self-determination. The structure or organization and delivery of health care in First Nations communities are not well documented in the literature. Warry (1998) argues that it would be difficult to examine how self-determination influences health care as there are many variables that can influence the level of self-determination that communities have or strive to achieve. Lavoie (2011) acknowledges that there is a patchwork of policies and programs to meet the health care needs of First Nations people, but does not provide any details about the organization of First Nations health care systems. Health Canada (2004) released the *Handbook on Health Transfer*, which vaguely outlined the necessary components of a First Nations health system that are required to enter into a health transfer policy.

In this study, First Nations leaders and health directors, and provincial and federal government staff were asked about the level of perceived control that First Nations governments and health authorities have over their

health care. The different perceptions of the level of influence or control by First Nations will be discussed in detail.

## Methodology

The current study emerged from a previous qualitative study (Expanding the CIRCLE) that examined the quality of diabetes care provided in four First Nations communities that were selected because of specific community characteristics (i.e., isolated, remote, close to an urban centre, increased number of follow up visits, etc.). Blood Tribe (Alberta), Wasagamack and Garden Hill First Nations (Manitoba), and Lac La Ronge Indian Band (Saskatchewan) were chosen and semi-structured hour-long interviews were conducted with the doctors, nurses, Community Health Representatives (CHRs), and patients in August and September 2010. Based on the analysis of these interviews, the current study was conducted to determine how much decision making authority or self-determination did the First Nations governments have over their health programs and services provided to their community, and what role does the degree of contact with western paradigms have on the perceptions of self-determination in health care by federal, provincial and First Nations bureaucrats and leaders. For the current study, an additional ten federal and provincial government bureaucrats were interviewed by telephone in June and July 2011. These participants were recruited through the First Nations communities and through snowball methodology. Table 1 shows number and description of participants used in this study. The qualifiers are the number of possible participants for each of the respondent groups. The study was approved by the University of Toronto Research Ethics Board in May 2011.

The study was designed using an Indigenous conceptual framework (the Medicine Wheel as shown in Fig. 1). After reviewing the findings from the Expanding the CIRCLE study and determining that there were varying methods of organizing and delivering health care in First Nations communities, a Medicine Wheel conceptual framework was developed to illustrate the interconnectedness between the socio-political history, the organization and delivery of health care, the perceived level of self-determination in each of the four First Nations communities and their health care system. The outer boxes in Fig. 1 show some examples of the traditional teachings given to the author as an Aboriginal person. The quadrants of the large circle relate to the traditional teachings in the outer boxes. As in life, the Medicine Wheel does not have to flow in only one direction, there are connections between all four quadrants and the themes represented here may have been missed in other frameworks. For example, culture and language are

Table 1. Number and description of participants for current study.

Respondent Title	Number of respondents	Qualifiers—number of participants out of the possible number of participants
Provincial government participants—with at least one participant from each province	4	1 of 5, Alberta 1 of 2, Saskatchewan 2 of 2, Manitoba
Federal government participants—with at least one participant from each region and one from National office	7	2 of 4, Alberta 1 of 2, Saskatchewan 2 of 2, Manitoba 2 of 50, Headquarters
Doctors	2	1 of 2, Blood Tribe 1 of 2, Garden Hill
Nurses	4	1 of 8, Blood Tribe 1 of 5, Lac La Ronge 1 of 4, Garden Hill 1 of 2, Wasagamack
Band council members with health portfolio or chief	4	1 of 2, Wasagamack 1 of 2, Garden Hill 1 of 2, Lac La Ronge 1 of 2, Blood Tribe
Health care directors or managers in First Nations	3	1 of 1, Garden Hill 1 of 1, Wasagamack 1 of 1, Lac La Ronge

embedded in all four quadrants in different capacities, but in a linear model, it would be difficult to show how culture and language impacts self-determination in each area. The Medicine Wheel teachings gained by the Aboriginal author throughout her life guided the analysis of the qualitative data in NVivo. Using the traditional teachings of the Medicine Wheel and the health care literature, themes emerged from the interviews that illustrated that there were many factors that were determining the perceived level of self-determination that First Nations communities may exert over their health care systems.

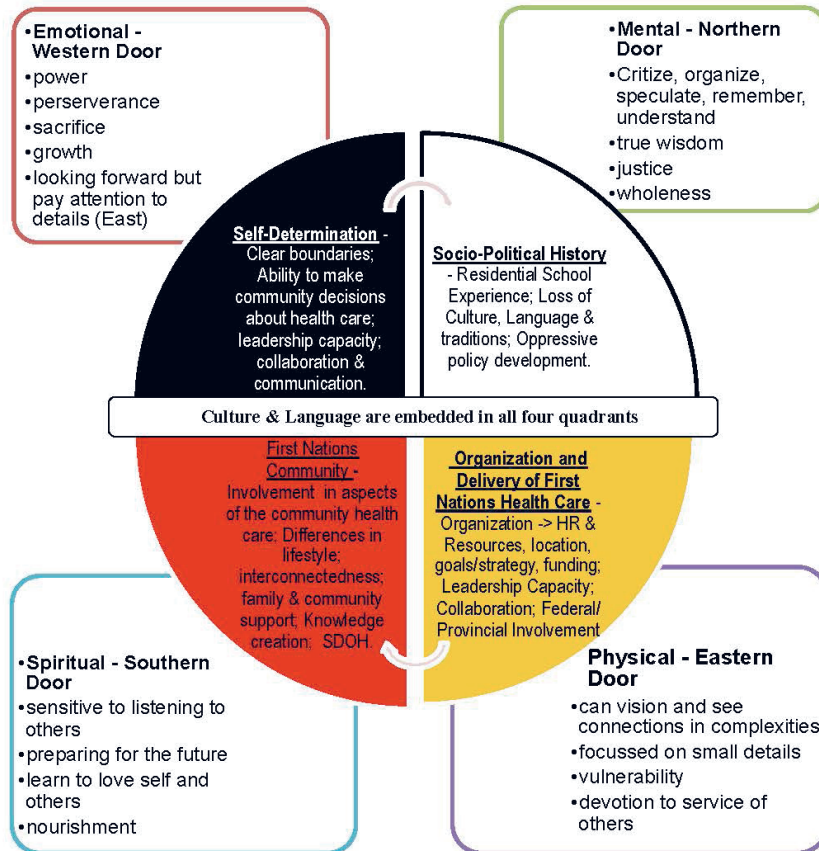


Fig. 1. Medicine wheel conceptual framework.

Many themes emerged through the analysis, but for the purposes of this paper, the definition and perceived level of self-determination that First Nations communities are perceived to have will be the only areas examined.

## Results

Self-determination in any aspect of a person's life can influence the other areas in their life; for example having choice to where to reside or being employed can change the income levels of individuals and families, which can then influence the amount of healthy foods that they can access. Self-determination for a First Nations community means that they have control to make choices to improve the health care and health programs and services for true change and benefits the community's needs; for example control

over who is employed in primary health care (i.e., doctors and/or nurses) can change how, when and where First Nations people access primary care to move from intervention to prevention of illness and disease. Despite the many limitations of the health transfer policy and Health Canada's lack of commitment to support true self-determination in health (Jacklin & Warry 2004), all four of the First Nations communities in this study have made strides in gaining greater control over their health services (i.e., health programs and services, and in some instances the primary health care provided). Self-determination in health is evident in all the communities as they have chosen strategies to help them to achieve their goals to improve primary care and specialized services. Each of the communities is aware of their progress and continues to work with their provincial and federal government counterparts to increase awareness and understanding of their abilities leading to self-determination.

The participants who were chosen from the federal, provincial and First Nations governments provided their perception of the level of self-determination that the First Nations communities had in their health care system. These perceptions were based on their knowledge of mainstream or western bio-medical health care and the ability of these First Nations communities to achieve similar systems in their communities.

#### *Federal Government Participants*

Through policies such as the Health Transfer Policy, Self-Government Policy, and the Indian Health Policy, federal government bureaucrats become familiarized with the government's definition of self-determination as part of their role in First Nations communities. Many of the federal government participants believe their role is to assist First Nations communities with increasing their leadership capacity. "[T]he more capacity they have, the more independence or the more flexibility that they can have around things" (federal government participant). Another federal government participant spoke about the role of bureaucrats working with First Nations: "so my primary objective is to facilitate health outcomes by increasing the capacity of community level to self-determine." First Nations and Inuit Health (FNIH), a branch of Health Canada, had staff assist First Nations communities with moving toward health transfer and then increased flexibility available under such an agreement according to some federal government participants.

When discussing the Health Transfer Policy (HTP), which provides First Nations communities with funding to provide public health and some primary care services, one federal government participant noted that there were "levels of agreements [HTP], based on leadership capacity and ability," with region-wide planning and delivery, leadership and capacity building



may not be as important in future agreements. However in “each community, the leadership can determine the direction and we don’t want or have any control over that” (federal government participant). This statement clearly is not pursued by all federal government bureaucrats as some of the federal government participants who work with First Nations communities state that there is established criteria that FNIH bureaucrats must apply to determine a community’s flexibility and control over their health system. In fact, some federal government participants stated that there are no published criteria for the communities, but that the relationship between the FNIH bureaucrat and the community as well as their previous experience with contribution agreement programs and services is considered when determining the level of flexibility assigned to a community.

Some federal government participants believe First Nations communities are moving toward more flexibility. Most of the federal government participants provided their interpretation of the guidelines to self-determination for First Nations communities to obtain control of their health care. When these participants spoke about self-determination, it was clear that the definition that they understood was to have the ability to make individual choice about when and where to access health care. Some of the participants noted that communities have control over the administration of the funding, planning the programs and services, but all participants said that First Nations communities, regardless of the flexibility they are afforded, must adhere to the guidelines for accountability that Health Canada has provided in the health transfer handbooks. All these participants agreed that strong leadership capacity was absolutely necessary in order for a community to move toward flexibility and self-determination.

In terms of the federal government participants’ perceptions of each of the four communities, it was acknowledged that Blood Tribe had the most control over their health care as they have strong leadership capacity and “a fair bit of administrative control” (federal government participant). Lac La Ronge Indian Band was perceived by federal government participants as having some flexibility in their health transfer agreement. Many of the federal government participants acknowledged that smaller First Nations communities must build their leadership and ensure that they have the appropriate level of capacity to receive flexible health transfer agreements and contribution agreements. Two federal government participants believed that the leadership in Garden Hill has already learned how to negotiate new partnerships and relationships in a way that will benefit the community’s health, and as such the community is moving toward greater flexibility and control of their health care system. In Manitoba, there was discussion with the federal government participants who believed the federal gov-



ernment was moving toward transferring nursing stations to the province and then from the province to the First Nations, but that this would take a vast amount of time before First Nations communities would have control over their nursing stations. Most federal government participants perceive strong leadership capacity, both at the band and health levels, as the key to increased flexibility that leads to self-determination.

#### *Provincial Government Participants*

Alberta, Saskatchewan and Manitoba have large Aboriginal populations and there are several treaties signed in each province. Provincial governments are responsible for providing and administering health care to all citizens in their jurisdiction as established in the British North America Act, 1867, but there are some notable exceptions including First Nations people living on reserves. As one provincial government participant explained “we are really aware of their treaty rights and don’t want to do anything to jeopardize them.”

The provincial government participants in Alberta believe that Blood Tribe “have complete control over their health care.” The Alberta government participants were more concerned with individual self-determination in health care than the collective First Nations community self-determination over the health care system. The provincial government participants stated that the Blood Tribe has a lot of control in their health system and were definitely working on full self-determination for individuals and families.

In Saskatchewan, the provincial government participant refrained from commenting on the level of control in Lac La Ronge Indian Band. However the participant did state that Lac La Ronge had access to a good health care system, which they could influence through partnerships and networking. The provincial government participant believed that Lac La Ronge had many challenges because of its size and geographic diversity, but “they are very much involved in a number of different initiatives” that may assist them in gaining leadership capacity for future self-determination in health care.

In Manitoba, the provincial government participants were interested in working more collaboratively with First Nations communities, but the local health care system was designed and delivered by the regional provincial health authority. In this way, regional health authorities have substantial influence with regards to the organization and delivery of health care, and by extension the level of self-determination, for “mainstream” Manitobans. One government participant noted

I think in some ways FNIH has kept them back. They have separated them from the RHAs [Regional Health Authorities] and the RHAs have services that can be helpful and assist them with having some self-determination in health care.

The participant believed that every First Nations community in Manitoba could become self-determining, but the First Nations authority for Garden Hill and Wasagamack (Four Arrows Health Authority) needed more control (self-determination) to work with provincial health authorities to then provide more self-determination to First Nations people.

All of the provincial government participants seemed to be more interested in individual self-determination rather than collective or community self-determination in health care on reserves. Some of the provincial participants noted that access to health care was the key to individual self-determination in health and that community self-determination was a matter to be discussed between the federal government and First Nations communities. Thus the provincial government participants stated that their mandate and goal was to assist First Nations communities, when called upon, with ensuring that individual First Nations people have access to the health care system provided by the province in order to improve the health of First Nations people.

#### *First Nations Leaders*

The Blood Tribe participants believe that their health care system has provided them with some level of self-determination, but their perception regarding the level of self-determination over health care is far less than both the federal and provincial government participants. The difference in perceptions of the level of control must be a factor in the organization and delivery of health care for the Blood Tribe because when an organization feels that they must follow guidelines and objectives, they believe they have less ability to provide their own input. Participants from Blood Tribe believe that they can make decisions and changes to the health care system wherever needed; Blood Tribe Health Department can be considered self-determining.

Lac La Ronge Indian Band participants felt that the community had some degree of self-determination in their health care, but Health Canada and FNIH have the ultimate control and could change the direction of health care when they feel because there is a need for transparency and accountability attached to the funding provided for in the health transfer agreement. As one Lac La Ronge participant stated, "if you make a drastic change in the [health] plan, well ..." the consequences can be severe. The Lac

La Ronge participants firmly believed that the Health Director could make small or subtle changes to the health plan, but major change could not occur without extensive consultation. One community participant noted that the five-year health transfer agreement allows the community to have control over the money (self-administration) that goes directly to the Lac La Ronge Health Services for the management and board to approve of the work plan. However there would be limited flexibility in changing the prewritten proposal documents that provided the money unless you were changing the community health plan, which only occurs every 5 years. Therefore the participants felt as though Lac La Ronge Health Services had limited self-determination.

For both Garden Hill and Wasagamack participants, they perceived that both communities had no control over the community's health care, but the health participant in Garden Hill felt they had a small amount of control in health care because they could have input into how the local regional hospital ran. In both communities, health care is arranged and provided by FNIH employed health care professionals, which some participants believed helped the communities with building leadership capacity and community development as they were not focused on recruiting and staffing health care professionals. However, these remote communities lack choices in health care because of their distance from other populations; these communities are 600 kilometres northeast of Winnipeg with only winter roads or fly-in possibilities.

## Discussion

The perception of control or self-determination varied depending on the level of government (federal, provincial, or First Nations) and the interactions the participant has had with First Nations health care systems. Federal government participants perceive self-determination to mean control of administrative processes, within strict parameters dictated by federal or provincial governments. Additionally, the provincial government participants saw self-determination from an individual perspective not a collective, but wanted to assist First Nations communities with gaining more self-determination in health from a provincial perspective. Community and health care professionals perceive self-determination to mean control over the allocation of resources and the uses of traditional medicines. There is clearly a difference in level of perceived self-determination that community participants see versus that of the federal or provincial counterparts, which can lead to the amount of support and flexibility the communities receive with funding, human resources, and leadership capacity development. Even the criteria for strong or effective leadership capacity are not created by First

Nations communities, but rather by federal and provincial bureaucrats. The definition of self-determination is a factor in the perceived level of control at various levels of government (federal, provincial, or First Nations), then it is important to allow First Nations leaders and governments to have input into the definitions that clearly affect their ability to provide health care and public health programs and services. Beyond the definition, it is clear that the criteria established for each label (i.e., self-determination, leadership capacity, health, health care, etc.) should be created in collaboration with First Nations health leaders (i.e., community Health Managers, Assembly of First Nations Health Director, Indigenous health scholars, etc.) to ensure that everyone from the federal government to health professionals are working from the same definition and criteria that will improve the health and well-being of every member of First Nations communities.

Warry (1998) discussed the need for communities to achieve self-determination in health care to achieve a health care system that was culturally appropriate and community sensitive. However if the different levels of government do not perceive the same level of self-determination, it may be difficult to attain the requirement needed to increase their flexibility, which in turn will increase their level of self-determination. The guidelines and criteria are created by non-First Nations people and those who may not be familiar with the realities faced in First Nations communities or the socio-political history that First Nations people and communities have faced. Therefore arguments can be made for either a western biomedical system only or a blended system, like the ideal First Nations health care system.

Lavoie (2011) found that First Nations communities do have some flexibility within their health transfer agreements, but that the government bureaucrats who oversee the agreement make the judgment of how much control a community may have. As Malloy (2003) argued, government bureaucrats can assess Aboriginal communities based on their individual perceptions and implement policies based on their individual interpretations, which could also impede these four communities from obtaining more control in their health care systems if the bureaucrats do not perceive the community as being capable of handling increased control in the health care system. For example, Wasagamack participants acknowledged the need to increase their leadership capacity, which Lavoie *et al.* (2005) argued is required for a First Nations community have any measure of self-determination. The government participants were aware of the limited control that Wasagamack First Nation had over the health care system, but most believed that it would take the community time to develop leadership capacity that would be able to effectively operate health services in the community. Both federal and provincial government participants suggested that capacity

building of para-professionals and cultural and history awareness training for government bureaucrats may assist Wasagamack First Nation (and others like it) in taking more control over their health care sooner. Training and education about the socio-political history and culture for government bureaucrats and para-professionals would assist with moving toward the ideal First Nations health care system as everyone would have similar knowledge and understanding of the needs of First Nations health, history, and culture.

The process of devolving health care actively engages First Nations communities and the provinces, which can lead federal, provincial and First Nations governments to find innovative ways to provide self-determination in First Nations health care (Rae 2009). In the province of Manitoba, there seems to be some discussion about devolving health care, which should increase communication and assist with increasing self-determination in health care. However, if First Nations communities are forced to take control of devolved programs or services, like health care, when the program's structure, reporting requirements and partnerships are already established, this produces self-administration, not self-determination (Rae 2009). It is important for all First Nations communities to attain true self-determination, not self-administration.

## Conclusions

All four First Nations communities have started their journey toward self-determination in their health care systems. The path that each community chooses is different and marked by different partnerships, collaborations, funding, communication, incorporation of culture, language and worldview, and proximity to non-Aboriginal towns and cities. The participants from the First Nations communities all stated their community had low or no self-determination in health care. This perception could be reflective of the unspoken desire to create the ideal First Nations health care system, which incorporates traditional healing and medicines with the biomedical health care system that all Canadians are entitled to and enjoy. This is important because if First Nations communities are striving from the ideal First Nations health care system, or a blended system, then their perception of how close the community is to having an ideal system would influence their perception of the level of self-determination currently experienced. Therefore many factors are influencing the perception of self-determination regardless of where a person is situated. The perception of self-determination in First Nations health care is influenced by employment (government bureaucrat versus First Nations leadership), knowledge of the socio-political history (advanced knowledge of assimilation policies and programs versus limited understanding and awareness of the traumatic

past), criteria about the health care system (biomedical health care versus the ideal First Nations health care system), and the experience of the health care system (patient and community member experience of the existing system versus an “outsider” perspective with knowledge of only a biomedical health care system). Therefore, the level of self-determination in each of the four First Nations communities appears to be at different levels depending on the participants’ vantage point.

The perceived level of self-determination is subject to the power and control that the federal government currently has over First Nations communities. The control that the federal government has can be seen as similar to a parent/child relationship, in which the First Nations communities are “growing up” and with maturity wish to take further control from the parent. This imbalanced relationship is replicated in the primary care provided to First Nations communities, with little input or acknowledgement of traditional healing and medicines that may complement the biomedical care provided. Further research and policy development will be needed to continue along the continuum of a blended health care system (biomedical and traditional medicine) that is clearly defined fully self-determining.

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