Community control of health services for Canadian Indians

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Many countries have a dominant culture and one or more minorities. Can a single type of health care therefore meet the needs of diverse populations? The health situation among the Indian populations in Canada could be improved by the "health transfer" initiative, which is described below.

Indigenous peoples are often difficult to reach geographically, and are also sometimes distrustful of the dominant group for cultural and linguistic reasons. In particular, they distrust the motives of non-aboriginal personnel and policy-makers with a history of colonialism (1), so that the successful delivery of health services takes on new meaning in terms of equity (2).

Community participation is seen as a cornerstone of primary health care: it is also essential as a response to the question "How can the dominant culture best serve minority groups?", since it makes possible health service delivery that does not follow too closely Western medical tradition but allows minorities to take from it what they can use in their own culture. Health information intended for one group of people tends not to be adaptable to the language and culture of others, and to ignore the needs of ethnic minorities. In southern Australia, attempts to devise a culturally oriented curriculum for aboriginal health workers made it clear that persons with a traditionally holistic view of health see "Western" health care as predominantly, if not purely, curative (3). In Canada, where arguments for health promotion versus treatment are very important to the quality of service, the experience is comparable.

Canada is often said to have one of the most equitable and progressive health care systems in the world. Although aboriginal people have full access to it, their health care needs differ significantly from those of the general population. In an attempt to allow for demographic and cultural variations and differences in health conditions, "First Nations" (Canada's Indian nations) entered into negotiations with the Federal Government to transfer responsibility for community health programmes to Indian control in the interests of a more appropriate response.
Aboriginal health in Canada

Since the arrival of the European settlers in the sixteenth century, virtually no aspect of traditional aboriginal life has been left unaffected. Historically Indian cultural areas, defined by the geographical environment, determined the tribe’s different social, political and spiritual ways of life. Today, approximately 60% of status Indians (aboriginal people allowed to register as Indians under Canadian law) live on reserves set aside for them.

The basic Indian political structure consists of the chief of a “band” (a group within a tribe) and a council at each level of government: reserve, district (comprised of several tribes), provincial, and federal. Although First Nations want self-government, the Federal Government currently maintains a traditional role under the Canadian Constitution to act as advocate for the interests of Indian communities in the larger Canadian society and its institutions (4). This traditional role forms the basis for Indian health services and programmes today. Aboriginal people, like all Canadians, have full access to publicly funded health care under the provincial governments. In addition to significant financial support for provincial health, the Federal Government also has the responsibility to provide services directly to Indian people. In an evaluation of Federal health services for Indians (4), it was recognized that these services did not improve Indian health status to the level of the general population because of poor utilization. For example, the mortality rate for Indian infants returning home from hospital after delivery was found to be three times the rate for non-Indians, and life expectancy was approximately ten years lower than that of the general population.

While the general population in Canada is aging, the Indian population is younger, with a peak at childbearing age. As First Nations are already among the most socially and economically disadvantaged groups in Canada, and births to unmarried mothers comprise approximately three-quarters of all native births, Indian women need different types of health services from those designed for the general population. Services must be adapted to the local level to cover more effectively those at risk. Each reserve is a separate community at a separate stage of development, so that generalizations are bound to be at variance with local viewpoints.

Health transfer initiative

The Medical Services Branch of Health Canada, a Federal Government organization responsible for providing additional health care services to Indian people, was created in 1962 to meet the Federal Government’s responsibilities for “Indians and lands reserved for Indians” (5). While, under the Canada Health Act, diagnostic and treatment services are provided to Indian people by the province of residence, many Indian communities are located in rural areas, and their health needs often require different approaches and services such as health promotion to reduce the high rate of diabetes among them compared with the general population. The Branch provides these additional services to reserves, where populations may vary in size, the average being approximately 500. An evaluation of Indian health services (6) strongly suggested that their effectiveness was often compromised by cultural differences between native people and the doctors and nurses providing services. The
recommendations stressed the need for more native involvement in staffing, and more appropriate training and orientation for carers.

Since the 1960s, these matters have come to the forefront of public interest and, with increasing pressure from First Nations for constitutional endorsement of Indian self-government, there was a change in Indian health policy in 1986. This was when the Canadian government initiated an approach to health development in reserves called the “Health transfer” initiative, offering an option to communities in reserves to negotiate with the medical services of Health Canada the transfer of funds for individual band control of certain public health programmes previously provided by the government. The types of services negotiable for transfer include community health work, nursing, environmental health, health education, and tasks related to managing clinics and their premises.

Future implications

There is a general feeling among the Federal authorities and Indian communities that despite local limitations, health transfer will increase awareness and lead to improved health in the communities.

Availability of staff

From the people’s perspective, health transfer will not reduce the need for improvements in understanding between them and health staff. Success depends largely on the availability of qualified professionals to provide or coordinate culturally appropriate services. The recruitment of such staff will continue to be a chronic problem for many communities located in rural and often isolated areas, because with limited funding for new or enhanced services there is little incentive to work on the reserves. If suitable applicants are not available, communities will not be able to make the transfer effective.

Many Indian communities are located in rural areas, and their health needs often require different approaches and services.

Although native staff recruitment is desired, the number of aboriginal graduates qualified to provide professional service is at present very small. The Federal Government has offered a variety of incentives to First Nations for continuing education – for example, university preparatory courses and scholarships – but an adequate pool of qualified health professionals is a distant goal. The difficulty is further compounded by the reluctance of young Indian university graduates to return to rural areas for work.

Quality of service

Professional quality may suffer from unclarity about the roles and responsibilities of health care workers on the part of local political leaders and administrations. Without a clear understanding of what nurses and other health workers do, the health staff may be underutilized or expected to perform functions beyond their competence; training must keep up with the need for new skills.

From this point of view, their work requires skills that are often not recognized. Nurses employed by Indian bands should not be expected to perform functions they consider to be beyond their ability; training for local community health workers must not be neglected.
Continuity

Programme managers may experience difficulties in creating the links needed for health transfer; only certain specific programmes are transferred to local control and there is no provision to meet self-determined needs in the community under other programmes. For example, if there is a school on the Indian reserve, the school health programme staffed and financed under the current administration and budget will be eligible for transfer; if there is no school, but a project is under consideration, there may be no funds available for a school health programme. Although it is possible to allocate funds from an existing programme to meet future needs, a more appropriate solution would be to give the opportunity to First Nations to determine such needs and then negotiate funding.

While the objective of the “health transfer” initiative is to allow Indian tribes and bands to design health programmes, establish health services, and allocate funds according to their community health priorities, the difficulties in assessing and implementing an appropriate programme are many. Other questions raised by the community approach to health delivery are whether communities will adequately evaluate the quality of service they receive and whether demand will create a disproportionate segment of the population left behind by social and health development. How this is resolved will determine the ultimate success or failure of this initiative.

References