

The Nature of Rural & Remote Nursing

Fact Sheet 5 Nurses and First Nations and Inuit Community-Managed Primary Health Services

Judith Kulig, DNSc, RN

University of Lethbridge

Martha MacLeod, PhD, RN

University of Northern British Columbia

Josée G. Lavoie, PhD

University of Northern British Columbia

FEBRUARY 2007



Aboriginal health-care delivery is a vital component of rural nursing practice in many parts of Canada. First Nations and Inuit communities are increasingly taking on the management and administration of health services and programs under the federal government's 1989 Health Transfer Policy, the 1994 integrated agreement model, or the 1995 self-government model. Registered Nurses (RNs) comprise an important part of the health workforce in First Nations and Inuit communities. The documentary analysis of the national study on rural and remote nursing practice (Kulig et al., 2003) identified that little information is available to RNs about community-based health services that are managed and delivered by First Nations and Inuit. This fact sheet aims to fill this gap.

GOVERNMENT POLICIES

The opportunity for First Nations and Inuit to exercise more control over their health services took root in the 1979 Indian Health Policy. The policy intended to address the health disparities identified by Booz Allen Hamilton (1969), while recognizing that First Nations and Inuit communities should play a major role in developing solutions. This study led to opportunities for First Nations and Inuit communities to administer separate contribution agreements for the Community Health Representatives and addictions workers. The goal was to improve the health of First Nations and Inuit communities to the same level as other Canadians.

There are currently four models in place (see Table 1): a separate contribution agreements model, the integrated agreement model, the health transfer model, and the self-government model (in order of increasing local management). Since 1994, FNIHB has been committed to handing over the responsibility for direct service delivery to First Nations and Inuit. As a result, communities who choose not to enter into an integrated, health transfer or self-government agreement have been given the opportunity to sign separate contribution agreements to manage local health programs. Offering a choice of models gives communities

flexibility in funding allocation in order to maximize response to local needs. First Nations and Inuit communities can opt to take on and deliver services previously available at the local, zone or regional level; they can take the funding and purchase services from the First Nations and Inuit Health Branch (FNIHB) of Health Canada or other providers, or they can continue to receive services from FNIHB. Within the agreements, program control is intended to move at a pace comfortable for the community. Health programs are developed to meet specific community needs, without compromising aboriginal or treaty rights. Moreover, to ensure that community health needs are met, programs include a number of mandatory elements, with an emphasis on public health.

The separate contribution agreements model occurs as a yearly or multi-year contribution; it strengthens the accountability of Chiefs and Council to community members. Under this model, nursing staff generally remain employed by FNIHB. The Health Transfer Policy, adopted in 1989, provides eligible First Nations and Inuit communities the opportunity to take over the administration and delivery of community-based and regional services. This health transfer model applies only to those First Nations and Inuit communities south of the 60th parallel. The integrated agreement and self-government models, on the other hand, are available to First Nations and Inuit communities in the Northwest Territories as well as to those communities south of the 60th parallel.

To date, approximately three-quarters of eligible First Nations and Inuit communities across Canada have signed an integrated, health transfer or self-government agreement. It is anticipated that by 2007, close to 100% of eligible communities in Quebec and Saskatchewan and nearly 60% of Manitoba and Ontario communities will be managing their own community-based health services through these mechanisms. In Alberta, over 80% of communities have preferred the integrated agreement model and most often receive their nursing services from FNIHB. Over 80% of British Columbia communities have signed either an integrated, health transfer or self-government agreement.

Table 1. Models of Community-Managed Health Services

Separate Contribution Agreements Model	Integrated Agreement Model	Health Transfer Model	Self-Government Model
<ul style="list-style-type: none"> • In place in communities that have not signed an integrated, health transfer or self-government agreement • The programs are defined by FNIHB and delivered by the community. • Each program and service is funded under a separate contribution agreement, some yearly and some multi-year depending on the program. 	<ul style="list-style-type: none"> • The community undertakes a planning process to identify needs and services. • Allows for the community to control specific aspects of community health services. • “Stepping stone”: this model was intended to be a preparation for the transfer process and to facilitate capacity building. 	<ul style="list-style-type: none"> • The community has flexibility in designing health programs and services, and in resource allocation. • Allows for community-designed programs and capacity building, but ensures mandatory programs are delivered. 	<ul style="list-style-type: none"> • Highest level of local management. • Treaty and aboriginal rights can be exercised within the constitutional framework. • Responsibility falls under Indian and Northern Affairs Canada.

released documents providing advice and assistance to communities about issues such as recruitment of RNs, legal requirements for supervision, and provision of professional development.

In preparing for employment by a First Nations or Inuit community, RNs are advised to:

- Understand and appreciate issues in First Nations and Inuit governance of health care;
- Establish supportive networks with other nurses who work in community services;
- Identify personal learning objectives in nursing skills and social-cultural health issues;
- Negotiate with the community for financial and infrastructure resources (e.g. time off) to support professional practice.

WHAT DOES THIS MEAN FOR RNS?

First Nations and Inuit health services across Canada will continue to become more locally operated, with increasing numbers of nurses employed by the community and fewer by FNIHB. Like FNIHB nurses, community-employed nurses practise within provincial legislation, including scope of practice and nursing standards. Where communities cannot recruit appropriately prepared staff, they may second FNIHB RNs through an Interchange Agreement. This can result in RNs being employed by FNIHB but supervised day-to-day by the community. In these situations, RNs on the same team may receive different salaries and benefits. Community-employed nurses will also have the opportunity to work in collaboration with community members and leaders to develop and implement innovative programs designed to improve family and community health. The inherent challenges in community-based health-care delivery models need to be acknowledged and addressed in a manner that does not compromise patient safety or professional practice.

Organizations such as the Aboriginal Nurses Association of Canada provide ongoing support to community-employed nurses. Their yearly conference provides an opportunity to meet and discuss issues with other RNs who work in First Nations and Inuit communities and to generate discussion about how to address mutual concerns. Support is also available to community-employed nurses from provincial colleges of Registered Nurses and from FNIHB, which has

Nursing in First Nations and Inuit communities has changed over time. As a result, community-employed nurses often work in challenging professional practice settings, where they are called upon to balance practice with managing the demands of a changing, often politically charged organizational environment.

References

Booz Allen Hamilton Canada Ltd. (1969). Study of Health Services for Canadian Indians Ottawa: Booz Allen Hamilton Canada Ltd.

Kulig, J., Thomlinson, E., Curran, F., Nahachewsky, D., MacLeod, M., Stewart, N., & Pitblado, R. (2003). Rural and Remote Nursing Practice: An Analysis of Policy Documents. Report # R03-2003 for The Nature of Nursing Practice in Rural and Remote Canada. Lethbridge, AB: University of Lethbridge.

Related Websites

First Nations & Inuit Health Contribution Agreements (2006). http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/index_e.html#Types_Contribution_Agreements

National Evaluation of the Health Transfer Policy (2005). http://www.umanitoba.ca/centres/centre_aboriginal_health_research/cahr-research/past_research/pastresearch-healthtransfer-english.html

The Nature of Rural & Remote Nursing is a series of fact sheets deriving from the research of the three-year project, *The Nature of Nursing Practice in Rural and Remote Canada*, supported by the Canadian Health Services Research Foundation and many co-contributors. The project's goal was to articulate the nature of registered nursing practice in primary care, acute care, community health, continuing care (homecare), and long-term care settings within rural Canada.

These fact sheets (and related tables and graphs) are posted on the project website at ruralnursing.unbc.ca. For further information write to rrn@unbc.ca.

Citation Information

Kulig, J., MacLeod, M. & Lavoie, J. (2007, February). Nurses and First Nations and Inuit Community-Managed Primary Health-Care Services. *The Nature of Rural & Remote Nursing*, 5. Retrieved from <http://www.ruralnursing.unbc.ca/factsheets/factsheet5.pdf>.