Promising Practice

Collaborative and Systems Approach to Transforming Primary Health Care in Manitoba First Nations Communities

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ABSTRACT

The models of primary health care currently operating in First Nations communities are rooted in policies that were crafted without prior appropriate consultations. Many have continued to be applied even though they no longer adequately serve the needs of First Nations communities and people, if they ever did. Transforming primary health care will necessarily involve community-inclusive and self-determined reviewing of existing policies with a goal of implementing opportunities to update policies and models of care. This study was a partnership with university-based researchers, a First Nations health and social development entity separately established by a regional organization of First Nations Chiefs, and eight First Nations communities. A multi-pronged methodology was used in which five concurrent studies employing qualitative, quantitative, and case-study methods provided information on the primary health care experiences of First Nations and rural and remote communities. The program of research took a community-based participatory approach to engage participants in designing and carrying out data gathering while strengthening local capacity and encouraging long-term ownership of the process of research for change. Participating communities pointed out key setbacks to community-based primary health care, including differing models of care, jurisdictional complexities, funding that creates isolated programs within the same community, lack of promotion of cooperation among health care services, and a general acute approach to health care service delivery in the community. These barriers are both problems and opportunities for change. A borderless health care system that is jurisdictionally seamless and that promotes collaboration through cooperative funding models that reflect community priorities is recommended and advocated for all Manitoba First Nations communities.

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Introduction

The Canadian government has a constitutional relationship with First Nations people (s) of Canada. First Nations peoples, based on oral history related to the negotiations of treaties, have for decades asserted that the fiduciary responsibility that Canada has toward them extends to their health and well-being (Boyer, 2014; Kornelsen et al., 2017). Canada has defined its obligations in narrower terms, asserting that service provision is a matter of policy (Lavoie et al., 2012). These divergent perspectives have undermined the relationship between First Nations peoples and the federal government (Allan & Smylie, 2015; Eggertson, 2015, 2016; Katz et al., 2017; Truth and Reconciliation Commission of Canada [TRC], 2015). Beyond an asymmetrical and often adversarial relationship, First Nations people have also been targets of discriminatory policies and practices (Green et al., 2013; Greenwood et al., 2018; Lavoie et al., 2016; Lux, 2016). The result of this history is evident in the poorer health of First Nations people compared to the general population (Adelson, 2005; King et al., 2009; Komenda et al., 2016; Luo et al., 2010; Pahwa et al., 2015; Shen et al., 2015; Smylie, 2012; Turin et al., 2016), which these authors have attributed to factors that include colonial policies, dispossession from their lands, and ongoing policy confusions (Brown et al., 2012; Gone, 2013; Gracey & King, 2009; King et al., 2009).

Attempts are being made to heal this long-troubled relationship and work toward reconciliation (Boksa et al., 2015; de Leeuw, 2017; Smylie, 2015; Smylie & Firestone, 2015; TRC, 2015). Recommendations of actions have included most prominently the 94 Calls to Action recommended by the Truth and Reconciliation Commission of Canada (2015). Through the First Nations and Inuit Health Strategic Plan (Health Canada, 2012), the First Nations and Inuit Health Branch (FNIHB) of Health Canada has been working toward four strategic goals:

- improve and attain quality health services
- improve health outcomes by strengthening partnerships with First Nations communities and other jurisdictions

- support access to high-quality data in order to facilitate health care planning and delivery
- support the development of cultural competencies and professional development

The last goal would presumably include cultural competence education for awareness orientations for non-Indigenous workers and upskilling of Indigenous community-based workers.

Background

In the Canadian province of Manitoba, the federal government, through the FNIHB, funds nursing stations in isolated and semi-isolated First Nations communities to provide limited primary health care under federal control. The federal government stipulates funding amounts and policies, which the staff in the federal nursing stations must follow. The nursing station is often separate from the federally funded community-based support programs, which are under local First Nations control. More accessible communities, including those in the south, use federal government funds for “health centres,” which provide limited public health services. The health centres are akin to dispensaries without the pharmacists or nurses who would normally be there. First Nations communities have very limited access to primary care locally, mostly through the occasional visiting family physician. Health centres focus on primary prevention activities, such as education about health and safety, or conducting home visits to support maternal and/or child health.

Current funding is organized and administered according to terms and conditions of contribution agreements, which are imposed and rarely if ever negotiated. Items of importance are determined based on poorly understood policies and outdated measures that tend to prioritize government assumptions and preferences over community direction. Funding flows from the federal government as part of the fiduciary relationship toward First Nations people and communities. Funds are normally funneled through FNIHB, a disbursing body whose role is to determine health needs in consultation with First Nations communities and to monitor implementation of programs according to health funding arrangements. Generally, FNIHB also audits program spending. First Nations communities, including those with health centres, receive “set,” “flexible,” or “block” funding for community-based programs. These funding options denote the varying degrees of malleability in the contribution agreements and indicate whether changes can be made in fund allocation. First Nations communities can request re-allocations in writing, subject to approval by the regional FNIHB office,¹ as long as mandatory programs to support local primary health care are delivered (Indigenous Services Canada, 2020). These mandatory programs generally include health promotion and disease prevention, public health protection, and primary care or clinical services where appropriate, mostly in the form of nursing stations. However, how this arrangement works on the ground can be a different picture, with FNIHB mostly dictating terms, conditions, and priorities for First Nations organizations.

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¹ In 2018-2019 the federal government organized a new Department of Indigenous Services (DISC), which combined Indigenous and Northern Affairs Canada and FNIHB services. It became a fully functioning and unified department on April 1, 2019.

In general, it is the First Nations organizations that, through decades of serving their own people, have evolved the current community-based programs to meet the needs of their communities, addressing gaps created by federal and provincial policies. Despite the First Nations addressing these gaps, access to specialized services and therapies, such as speech, language, and occupational therapies and therapists, has been very limited or non-existent in First Nations communities. More recently, however, community-based programs guided by such policies as Jordan's Principle, a child-first initiative, are applying funding to provide access to such therapies (Jordan's Principle Working Group, 2015).

The Innovation in Community-Based Primary Healthcare Supporting Transformation in the Health of First Nations and Rural/Remote Manitoba Communities (iPHIT) program of research is a partnership between university-based researchers, the First Nations Health and Social Secretariat of Manitoba (FNHSSM), and eight First Nations communities in Manitoba. The study team took a multi-angle approach, setting out to understand the barriers in community-based primary health care (CBPHC) in specific First Nations contexts and to examine community-based priorities and solutions to existing barriers. We consider viable CBPHC to be care that is underpinned by comprehensive primary health care along with multi-sectoral approaches to reduce inequalities that cause or exacerbate ill health in populations (Bhutta et al., 2018). A key goal as well was to understand the primary health care experiences of First Nations peoples and communities, and to highlight strengths in, and innovations being applied to, primary health care service delivery despite geographical, human resources, and funding challenges. While several strengths were identified, one area that continues to plague CBPHC service delivery is access to funding. This paper presents the perspectives of the participants in this study, and advances representative recommendations of the eight First Nations communities.

Methods

A multi-pronged methodology was used in which five concurrent studies employing qualitative, quantitative, and case-study methods gave information about the primary health care experiences of First Nations communities, and rural and remote communities. However, the current article reports on the qualitative component of the study, which took a community-based participatory approach in engaging participants. Community partners took the lead in designing the study from conception, supporting the writing of the funding application, developing research questions that would be relevant and address community priorities and needs, gathering data, monitoring data gathering, and participating in data analyses. Local research and project management capacity was developed through training of community partners, knowledge-sharing meetings, and conferences that occurred weekly, monthly, bi-annually, and annually with stakeholders in the communities. Long-term ownership of the process and change was encouraged through adherence to First Nations OCAP principles.¹ The iPHIT research team

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¹ Standing for ownership, control, access, and possession, OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC; <https://fnigc.ca/ocap>).

made itself accountable to the participating communities through frequent information updates. Participating communities also determined how information would be collected and by whom, all data was stored and managed at the FNHSSM, communities were assured of access at any time, and they determined the dissemination process, including vetting of publications (First Nations Information Governance Centre [FNIGC], 2014). A detailed description of the methods used in the program of study is described in previous publications (Kyo-on-Achan, Lavoie, et al., 2018; Phillips-Beck et al., 2019).

Ethics approvals were obtained from the University of Manitoba Human Research Ethics Board and the Health Information Research Governance Committee at the FNHSSM. Informed, free, and prior consents to participate in the study on a collective basis, communicated through Band Council Resolutions, were obtained from all participating First Nations communities. Advisory councils in each community also provided ongoing advice and guidance on community protocols, in addition to following First Nations research OCAP principles (FNIGC, 2014; Schnarch, 2004). In practice, all data collected for this program of research was returned to communities in the formats they requested (e.g., workshops, factsheets, presentations, and information booths or sessions at events in the community, such as health fairs). The overall dataset is housed at the FNHSSM offices, where the data was analyzed and much of the work of dissemination is being done. The FNHSSM continues to provide overall project oversight.

The partnership was with eight First Nations communities representing four rural and remote communities served by nursing stations in the north, and four rural communities served by health centres in the south. Non-First Nations communities were not included in this study. The remote northern communities served by nursing stations are funded to deliver prevention-oriented programs and primary care provided 24/7 by nurses with an expanded scope of practice. In contrast, rural southern First Nations communities served by health centres have access to the same prevention programs but do not have on-reserve access to primary care—that is, nursing care—with or without an expanded scope of practice (Lavoie et al., 2005).

The community-based participatory approach ensured that all participating communities could take ownership of the research process, including collaborating on study design and leading data collection, data interpretation, and knowledge sharing. Data collection was conducted by local research assistants (LRAs) trained in conventional data collection procedures, contextualized by significant experience in understanding and enforcing community protocols and interaction modalities. LRAs had in-depth understanding of the issues facing the communities they live and work in. They acted as a liaison between the First Nations communities and the research team.

Purposive sampling was used to target male and female community members, First Nations and non-First Nations health care workers,¹ health services users, and Elders. There were 183 key informant interviews and three focus groups completed across all communities. One

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¹ The “non-First Nations” are respondents who live and/or work in the participating communities. Some, in the course of being interviewed, mentioned that they were not from the particular community or not of First Nations ancestry. However, this dichotomy did not impact the data or analysis as the individuals understood and appropriately communicated the state of health and health care in the communities where they lived and/or worked.

small community of about 800 people conducted 10 interviews; three other small and medium communities of less than 3,000 people each conducted about 20 key informant interviews. Two larger communities of up to 5,000 people each had 30 interviews. The largest community, with well over 8,000 people, had 50 interviews.

Data were transcribed verbatim. Transcripts were checked for accuracy and then uploaded to NVivo 10 for further organization and management. Constant comparative analysis surfaced codes and ideas that emerged as the themes that identify policy barriers to CBPHC transformation in the participating communities. Once preliminary data analysis began, the LRAs were instrumental in organizing community feedback sessions, where the results were presented to the community and all members of the community present (including participants) could reflect on, question, and discuss the results, providing additional information or comments. Data and results were provided to communities in various formats: factsheets in lay language; workshops; presentations by the researchers, who also fielded questions and explained the research process at every juncture; and community events such as health fairs, where researchers participated to provide information to community members and respond to questions. Community members often made comments that were confirming of the data and sometimes provided examples or personal stories along the lines of the data.

Gatherings were held with northern (rural and remote communities) and southern (rural) communities separately, as issues generally differ between regions. The purpose of these meetings was to provide updates on progress engage in interpretation of data, and collectively plan next steps in the research process. At these meetings, northern and southern community participants saw, heard, commented on, and interpreted the results from their own and the other communities. Community members also engaged with each other and shared information with regards to their health care experiences. They drew common threads, pinpointed common setbacks, and shared unique solutions, giving life to the data analysis and enabling articulation of what community members were ontologically aware of, but had not validated until they heard others' experiences and articulations. Thus, participants started to map a big picture and draw useful parallels and connections. The success of this model is that the research process allowed all partners to also reflect on factors affecting health and health care in First Nations communities that, while important, lay outside the scope of the study questionnaires.

Results

This section reports four themes inducted from the rich data:

- Differing models of care
- Jurisdictional complexities
- Funding that creates isolated and siloed programs
- Lack of collaboration and cooperation among programs

Some differences were evident between urban versus rural communities, rural versus remote communities, and rural and remote First Nations communities versus what is observable in rural non-First Nations communities.

Differing Models of Care

Participants in this study repeatedly reported concerns over differential and arguably substandard health care for First Nations peoples and communities, due in part to policies governing funding for health care services in First Nations communities.

Vast differences are observable between health care services on reserve (rural) and off reserve (urban or rural and/or remote non-First Nations communities). One participant echoed others in commenting on health care facilities in the community (on reserve):

[It] seemed, well, like they were prepared for everything there [off reserve]. They seemed to know what they were doing. And I know it's probably because of the size of the facility that they were able to do that. I think it's probably the range of care that can be provided [at a facility]. Like for instance, going back to the procedures, I don't think we're set up [on reserve] to have procedures where we have to do what a lot of people need. We have to send them to different hospitals and stuff like that ... technology is probably what would be the big difference. Hospitals in the city and the health centres are better equipped to handle the wide range of [health care needs].

Another participant said:

See, say somebody is having a heart attack, if you were [off reserve], right away, like, in five minutes you'll have access to health services. If it's in the [First Nations] community, it'll probably be too late ... We don't have ambulances to get that person that's having a heart attack to a nursing station. It'll take, like, at least 15 minutes or more and then get there and there's just a nurse. There're no doctors. There's no trauma centre, nothing. Right now we only have a nursing station ... They have a nurse there. Sometimes there're two nurses there, and what if there's a major emergency? What are they gonna do? I know they do their best, but it takes a plane to get over here in more than hour. Even if we call a life flight it takes, like, two hours. We lose a lot of people like that.

Additionally, participants lamented not having enough staff and equipment at facilities in the community:

Here we are a nursing station, right. We are so limited because we cannot do ultrasounds, we cannot do same-day lab work. If someone presents with an acute problem, let's say a heart attack or maybe we think they're having a stroke, of course they have to leave [the community]. We don't have those services ... So there's a lot of travel involved for especially things like heart attacks or strokes or something that could be catastrophic that we do not have. There's other things, for instance, in this community where we have such a prevalence of diabetes, we do not have a dietician, we do not have a diabetic

educator, we do not have a diabetic team, we do not have a diabetic foot care nurse, we do not have a diabetic program at all. And this is a huge disservice to this community. We have an Aboriginal Diabetes Initiative worker who does prevention, but it is not enough. We have people who have terribly uncontrolled diabetes.

Other participants shared similar examples and raised concerns about how circumstances such as these can go unabated for lengthy periods, especially since urban centres and other rural and remote non-First Nations communities observably provide better services. This glaring disparity led to one First Nations Chief's remark that "Us First Nations are treated as chattel. We are an industry, we are used for business for others to live on" (Chief Cathy Merrick, personal communication, 2016).

Jurisdictional Complexities

Jurisdictional complexities are said to be hindering access to services that are otherwise commonly available through the standard provincial health care system. For example, speech therapy, occupational therapy, physical therapy, and mental health services are available to other Manitobans, including those who live in rural and remote communities that are of similar size to First Nations communities. However, participants reported that they sometimes could not access available care due to being on reserve and being considered federal responsibility. One mental health worker's difficulty in referring patients provides an example:

I would like to tap into the provincial services more where mental health is concerned. In order for me to tap into a provincial service I would have to relocate my client, [but] because we are federal here, we can't tap into provincial services because of where we are. [Some services] that are provided by provincial funding can't come here [into the First Nations community] and we do have a lot of clients that are mentally ill.

Similar examples abound of how jurisdiction-based funding and programing has limited access, constrained programs, and, by extension, impacted individuals' health. This continues to inflict hardships on First Nations patients. Many struggle to access health care in two jurisdictions, a situation that is not of their own creation, as this participant shares:

There is a lot of advantages for [my sister] living outside the reserve. She can access, like, a speech therapist for her kids, and I know outside [the reserve] it's really difficult for them and inside the reserve it's difficult too. I know there's a lot of barriers here on the reserve to access care because they say that we're federally funded, therefore we cannot access provincial programs. There's a lot of money that we cannot apply for or we're not eligible because we're federally funded ... There are lots of barriers.

I think the really big difference is the jurisdictional barriers imposed on us. I think more services are made available out of [our] community than there is in the community.

These jurisdictional complexities create eligibility roadblocks for patients attempting to access care, obtain a diagnosis, or access ongoing supports for chronic health conditions. In some cases, as stated above, they can prevent First Nations communities from reaching for additional funds to augment programs and services on reserve.

Funding That Creates Isolated and Siloed Programs

First Nations communities have instituted community-based health programs that do not amount to primary health care in the conventional sense of access to family physicians, nursing care, and diagnostic services. In reality, various isolated programs deliver preventive health education by providing basic health information. These programs operate in facilities outside of the nursing station and do not share data to facilitate coordinated care. These mutual blind spots may create barriers for clients seeking care. One community member echoing others, stated that

Quality health care is to have a good nursing station with all the programs that's needed, you know, like NNADAP [National Native Alcohol and Drug Abuse Program] and mental health and the nurses here and the medication is here, having all those services here [at the same facility in the community].

Nurses are the primary clinical care providers in First Nations communities with nursing stations; however, nurses who manage or coordinate many of the funded community-based programs are administrators and supervisors. While federal funding for nurses in administration and supervisory roles may be characterized by the federal government as a form of “primary care,” these nurses cannot be counted as providing clinical care. So while there are programs operating independently to serve the population, some still do not consider there to be much healthcare in the communities.

Well there's not that much health care out in the community. There's not that much choices, just what they have out here [programs], like, that's all they have. There's way much more in [the city].

Making sure that our community members are well taken care of and that they understand there's a system that we live in as First Nations people and it can get very confusing ... making sure that ... [the programs] are all working together ... We always talk about a holistic model for our members.

The latter respondent is communicating widespread confusion when programs in the community operate in isolation of one another, creating fragmentation due to funding mandates and absence of information sharing. That system is said to create confusing silos of funding and

reporting, which makes communication and management of these programs difficult in First Nations communities.

Lack of Collaboration and Cooperation among Programs

According to participants, lack of collaboration and cooperation among health programs is created or fueled by funding mandates that impose policies which make meaningful collaboration difficult. The following quote aptly captures the sentiment:

There's a lot of resistance because we [health care workers] don't want to share information. Again, the policy states it's confidential. I'm not supposed to share this. And for example, [people say] this is my client, my program, my budget. And that kind of confidentiality just totally hurts. Just like, for example, when somebody works with the finance, they say it's mine and I'm not gonna share it. That white man brought that here when they didn't want to share with us Aboriginal people. We shared all the time. We shared everything and that's a good example.

The result then becomes that workers in the various funded programs focus on implementing individual mandates without much room for cooperation and information or resource sharing with other programs. In this way, funding dictates how people experience primary health care as various isolated programs. Differential mandates may drive wedges between programs and prevent cooperative information sharing to aid intersectoral collaboration.

Discussion

The results of this research suggest that policies governing health care models in First Nations communities are not fully delivering desired results. The eight First Nations in this study strongly asserted that barriers to health care delivery in First Nations communities are attributable to the models of care currently in operation in First Nations communities, as well as to misaligned federal and provincial jurisdictional priorities and funding models. Evidence shows that policies were never intended to provide full and complete health care services for First Nations peoples and communities (Lavoie, 2013; Tobias et al., 2020). There is broad consensus among First Nations that health care policies and funding models must be applied in ways that promote what has been termed a “borderless health care system,” a phrase first used by a Health Director in one of the participating communities. The word “borderless” was used to express the innovation that could counter and eradicate health care case management difficulties created by funding models, jurisdictional barriers, and lack of information sharing among local programs responsible for delivering health care services in First Nations communities (Lux, 2016; TRC, 2015). “Borderless” also refers to clients and their families not experiencing the presence of walls and barriers that hinder fluid movement from community-based to off-reserve (urban and other rural) services and care. Borderless health care sets the direction forward to timely and quality health care for First Nations without being or feeling trapped in jurisdictional

bureaucracies that limit holistic and effective health care delivery. Federal and provincial jurisdictions must create ways to communicate with each other regarding First Nations health to reduce confusion and health care systems navigation horrors.

First Nations participants in this study indicated a desire to disburse their contribution agreement budgets in keeping with the most pressing community needs and priorities rather than with FNIHB mandates and directives, as they have done to date. Hence, FNIHB's current move toward non-prescriptive funding to First Nations communities, which facilitates First Nation control of unrestricted funds to be deployed in approaches or programs that reflect local priorities, is a welcome development. Better CBPHC may be established under First Nations management. Studies have shown that communities exerting greater control over their funds and health care have fared better in ensuring timely access to care and seamless health care administration than those that have not (Lavoie, 2013; Lavoie et al., 2007; Lavoie et al., 2010). Several First Nations in Manitoba have documented similar experiences (iPHIT Research Conference, 2018).

Additionally, First Nations promote an integrated and holistic approach to health and health care (Kyoon-Achan, Avery Kinew, et al., 2019; Kyoon-Achan, Lavoie, et al., 2019; Kyoon-Achan, Phillips-Beck, et al., 2018) as a more effective replacement for cross-jurisdictional case management difficulties imposed by diverging funding mandates. Funding should be made to promote teamwork, case coordination, and holistic approaches in First Nations communities. For example, CBPHC teams could include physicians, nurses, dietitians, technicians, Elders, mental health workers, traditional health workers, and relevant others working together, as participants in this study have requested. These teams could draft informal agreements to allow for respectful and confidential information sharing within privacy bounds.

To this aim, all stakeholders, including the FNIHB regional director, programs managers, and health care workers, will need to support full implementation of the renewed goals and objectives stated in the First Nations and Inuit Health Strategic Plan (Health Canada, 2012). They must all approach CBPHC with a willingness to encourage real collaboration on the ground and to re-evaluate funding mandates and requirements to make them align with community-determined goals. A system that works for people and promotes a spirit of sharing in community-based programs can reach across stipulated barriers to work together. Taking a collaborative and systems approach to service delivery may also positively blur jurisdictional lines so that community-based programs funded by either the federal or provincial jurisdictions in the same community can share expertise and resources, and work together. Again, informal sharing agreements could be drafted and respected by the various programs. The importance of respect among jurisdictions working together cannot be overstated. Information sharing can support a borderless CBPHC system. Additionally, First Nations may find that having access to their own health information and data could promote effective collaborative planning teams in the communities and might assist in building evidence for and implementation of needed change. Data-sharing agreements could be developed at the discretion and control of the First Nations community, as is presently promoted by the FNHSSM.

A tendency to think of various programs in the community as constituting primary health care was evident in the data as well as at annual iPHIT research conferences that brought all participating communities together. Virtually all community representatives reeled off a list of programs available, or soon to be available, in the communities, and all began their narratives with the same mix of federally funded programs. While having several diversified community-based programs can be beneficial, a bigger picture of creating and delivering consolidated primary health care services is not being achieved. Consistency and continuity may be compromised as people seek care from program to program, attempting to mesh isolated services to meet health needs. For example, a pregnant woman without access to a family physician or dedicated obstetrician may resort to attending as many as five to seven separate programs to fill the gap, and still leave the community for medical care when due to deliver.¹ Fragmented care does not adequately substitute for optimal primary health care in the conventional sense. Programs can be continued as supports to qualified medical care, but proper medical care is required at health care facilities in all First Nations communities.

Patients in some First Nations communities experience difficulties when trying to access services readily available through the provincial health care system. While progress is being made with accessing services such as occupational therapists and speech pathologists through new funding to initiatives such as Jordan's Principle and the Manitoba First Nations Education Research Centre, more needs to be done to close gaps. First Nations communities could retain the right to hire, monitor, and fire all health care professionals, which could permit the hiring of specialists to service communities on their terms. Additionally, First Nations could require that the health care professionals providing services in their community have a standard of cultural understanding and competency. This would be in keeping with the United Nations Declaration on the Rights of Indigenous Peoples (2008) and the inherent right to self-determination.

Professional and technological development in First Nations communities could enhance expertise and expand access to care and resources, including cross-community sharing of best practices and innovations. Sharing of knowledge, information, innovations, and models can be promoted through telehealth facilities. Telehealth is perhaps the most exciting technological development in First Nations communities right now. It has afforded interactions between health care facilities, among health care professionals, and with patients in ways that were previously not possible. While this service is useful in closing some gaps, it has serious limitations in delivering quality of care. For example, telehealth is not available in all communities and depends on reliable internet connectivity. In addition, for many Elders, sitting in front of a

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¹ In her community, the expectant mother might access the following services and programs: (a) nurse for clinical care, (b) maternal child health program, (c) prenatal nutrition program, (d) community counselling program, (e) fetal alcohol syndrome disorder program (if needed), (f) Aboriginal diabetes initiative (if needed), and/or (g) other traditional focused programs. She could also have a family physician who visits the community and could travel to see her ob-gyn. To an onlooker, this seems like very good coverage. However, small rural and remote communities may never have the same local access to care as urban centres because of basic economics.

computer may not be the same as face-to-face counselling, and some physical symptoms may not be seen by a physician diagnosing via telehealth.

Community-based research initiatives can also be funded to generate specific local evidence to be applied toward policy development. First Nations communities would partner with academic or other institutions to generate evidence that First Nations communities can use to improve CBPHC. With available funding, First Nations communities can consider funding their own research priorities or contribute financially or in kind to evidence-generating programs of study. In a similar vein, policies relating to CBPHC that are obsolete, spent, and counterproductive should be reviewed and reformed or deleted by committees that include First Nations representatives. CBPHC policy reviews could be carried out periodically to reflect new and ongoing health and health care realities. The Institute of Indigenous Peoples' Health (IIPH) at the Canadian Institutes of Health Research is beginning to support such processes (Canadian Institutes of Health Research, 2019). Political representatives, local leadership, Knowledge Keepers, and community members could all lend voice to policy review processes as opportunities for self-determination and supports of community ideas and solutions. Stronger fiscal relationships should support First Nations communities trying out, evaluating, and improving new models, ideas, and programs after sufficient maturation.

Conclusion

Inherent discrimination that prescribes differential health care models for First Nations communities in both the north and the south, even when compared with what is observable in rural and/or remote non-First Nations communities, needs to be addressed. The stark differences are indicative of barriers that keep First Nations people and communities outside the “regular” models of care that are readily available to all Canadians. Part of addressing this discrimination is to properly fund communities and properly remunerate CBPHC and the medical professionals that are needed in First Nations communities. The current CBPHC models, in which programs are funded in ways that maintain isolated and siloed operations in First Nations communities, should be reviewed and reformed to appropriately serve local needs. Confusions created by federal and provincial jurisdictions, which result in people being pulled in different directions and channelled into different programs with various diverging mandates, are a disservice to health and the health care system. The First Nations individuals and communities in this study want a seamless way of providing CBPHC, with funding at the discretion of First Nations communities. They recommend primary health care innovations that will be designed to meet the needs of the people and build on existing values and successes as decided by various communities. Ultimately, First Nations communities in Manitoba are advocating a borderless health care system with timely access to quality care and healing ways that are chosen and wanted by the people.

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