NHLC 2017 PLENARY SESSION

JUNE 12, 2017, VANCOUVER

ADVANCING THE TRUTH AND RECONCILIATION COMMISSION’S HEALTH-RELATED CALLS TO ACTION:

How do we achieve better value, higher quality care, and better outcomes for Canada’s Indigenous populations?
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Advancing the Truth and Reconciliation Commission’s Health-Related Calls to Action: How do we achieve better value, higher quality care, and better outcomes for Canada’s Indigenous populations?

At the 2016 National Health Leadership Conference (NHLC), co-hosted by HealthCareCAN and the Canadian College of Health Leaders, over 700 health leaders selected and debated a number of priority policy issues as part of the Great Canadian Healthcare Debate. After a rigorous process, the resolution identified as the top priority, (73% from over 750 delegates) was to take action on the implementation of the health-related Truth and Reconciliation recommendations. Delegates highlighted that this should be a priority, not just for 2017, but until the recommendations are fully implemented.

In response to the 2016 debate, this year’s health leadership conference will feature a special plenary session moderated by Duncan McCue (Reporter and Host of CBC Cross Country Checkup) entitled, “Advancing the Truth and Reconciliation Commission’s Health-Related Calls to Action: How do we achieve better value, higher quality care, and better outcomes for Canada’s Indigenous populations?”

As background to this plenary session, below please find:

1. Information on the Truth and Reconciliation Commission of Canada;
2. Background document provided by Speaker #1 – Ted Quewezance, Chair, Senate of Federation of Sovereign Indigenous Nations of Saskatchewan, Finding a Process for Truth, Reconciliation and Health Transformation in the Indigenous Health Alliance Project;
3. Background document provided by Speaker #2 - Joe Gallagher, Chief Executive Officer, First Nations Health Authority, First Nations Health Authority Profile;
4. Background document provided by Speaker #3 - Dr. Nadine Caron, Co-Director, UBC Centre for Excellence in Indigenous Health, A Canadian Responsibility: Turning Stories Into Action; and,

Background on the Truth and Reconciliation Commission of Canada

The Truth and Reconciliation Commission of Canada was established in 2008 as a result of the Indian Residential Schools Settlement Agreement (IRSSA), the largest class action settlement in Canadian history. In May 2006, the IRSSA settled multiple class action suits against the Canadian government, Anglican Church, Presbyterian Church, United Church and Roman Catholic Church by past full-time students of Canada’s Residential School system which operated from 1884-1996.

At its peak, the residential school system operated 130 schools in every province and territory except for Newfoundland, Prince Edward Island and New Brunswick. It is estimated that 150,000 First Nations, Métis and Inuit children were forcibly removed from their communities to attend the schools. The class action suits represented an estimated 80,000 surviving residential school survivors who were enrolled in the schools full-time. It is important to note that IRSSA did not include students who attended residential schools as “day scholars.” In June 2015, The Federal Court of Canada approved a motion for two First Nations in British Columbia to proceed with a class action suit for these day students.
As a result of settlement negotiations within the IRSSA, Canada was required to provide sixty million dollars for the establishment and work of the Truth and Reconciliation Commission. The Commission was mandated to: “reveal to Canadians the complex truth about the history and the ongoing legacy of church-run residential schools...” and, “guide and inspire a process of truth and healing, leading toward reconciliation within Aboriginal families, and between Aboriginal peoples and non-Aboriginal communities, governments, and Canadians generally”. The Commission reviewed thousands of documents and heard from hundreds of witnesses at national events in Winnipeg, Inuvik, Halifax, Saskatoon, Montreal, Edmonton, and Vancouver.

In December 2015, the Truth and Reconciliation Commission released its final report. The Commission’s report highlights some of the troubling disparities in health outcomes between Indigenous and non-Indigenous Canadians, including:

- An infant mortality rate for First Nations and Inuit children ranging from 1.7 to over 4 times the non-Indigenous average;
- Nearly twice the rate of diabetes among Indigenous people aged 45 and older compared to non-Indigenous people;
- An overall suicide rate among First Nation communities that is about twice that of the total Canadian population;
- For Inuit, the rate is still higher: six to eleven times the rate of the general population. Aboriginal youth between the ages of ten and twenty-nine living on reserve are five to six times more likely to die by suicide than non-Aboriginal youth;
- Other health disparities include: much higher maternal mortality and morbidity rates; dramatically shortened life expectancies; and, heavy infectious disease burdens.

The report noted that Canada has a long history of colonialism in relation to Aboriginal peoples. This history and its policies of cultural genocide and assimilation have left deep scars on the lives of many Aboriginal people, on Aboriginal communities, as well as on Canadian society, and have deeply damaged the relationship between Aboriginal and non-Aboriginal peoples. The Commission identified reconciliation as an avenue to repair these relationships.

The Truth and Reconciliation Commission released an executive summary in June 2015 with 94 recommendations — referred to as “Calls to Action” — which cover the broad themes of child welfare, education, language and culture, health and justice. The “Calls to Action” are aimed at redressing the legacy of residential schools and advancing the process of Canadian reconciliation. The complete text of the health related recommendations can be found in Appendix A.

The “Calls to Action” envisioned a role for all Canadians in improving outcomes for Canada’s Indigenous peoples. Significant actions have been taken by governmental and non-governmental actors - including many major health stakeholders - since the release of the Truth and Reconciliation Commission’s Calls to Action – but the work has only just begun.

While the majority of the recommendations were directed at the Federal government, all levels of government and many different organizations will be required to work in partnership to ensure effective solutions. Canadian health leaders, and the organizations for which they work, have a major role to play in helping to close the Indigenous health gap.
Background document provided by Ted Quewezance, Chair, Senate of Federation of Sovereign Indigenous Nations of Saskatchewan

Finding a Process for Truth, Reconciliation and Health Transformation in the Indigenous Health Alliance Project

Despite nation-wide efforts towards reconciliation, progress remains slow. There are profound undesirable consequences to Indigenous People, if slow or ineffective reconciliation in Indigenous health systems persists: widening of health disparities, deaths, devastating human costs, loss of economic and educational opportunities for Indigenous patients and families, escalating healthcare costs, expanding federal bureaucracy, expanding federal fiscal/legal liability and impacts on other priority policy areas including energy, economic development, among others. There is also the loss of the opportunity as the positive impacts of reconciliation are not being realized across all other Indigenous public policy areas.

The Indigenous Health Alliance has utilized the ALIGN model of Truth and Reconciliation to articulate the practical requirements of truth and reconciliation in health. The ALIGN model uses three tool types; decision-making, project management and system alignment.

Over three years, stakeholders within the pentad partners in health (patients/First Nations/community, academics/researchers, policy-makers, health providers and government) were involved in the creation of a process articulated through application of these tools. A common story was also articulated; perpetual crisis, leading to meetings, solutions and implied impact in decreasing crisis. Consistently the result of reducing crisis was rarely realized. Continued consultation and truth telling revealed a separate cycle, occurring concurrently with the inner circle. The process and cycles are illustrated below and are part of the ALIGN Model. The cycles are referred to as the inner and outer circles, respectively.

The ALIGN Model Process and Cycles

**Phase I: Establishing Truth** - Gathering stakeholders and separating into groupings, articulating the Common Story, mapping processes within the Common Story (patient journeys, decision-making, policies, legislation), priority alignment between groupings

**Phase II: Finding Reconciliation** - Establishing value, committing value, creating a common strategy, foundational principles, measurement of outcomes, exit strategies.

Dysalignment between the inner and outer circles exists because entrenched special interests leverage structural accountabilities to ensure individual/organizational priorities/outcomes are resourced rather than the priorities/outcomes of patients/First Nations. These entrenched special interests can be among any of the pentad partners.

In colonial systems, dysalignment is intentional. Intense, perpetual crisis was desirable for colonial system designers to weaken the Rights of Indigenous Peoples to land and resources, a historically desired outcome which in the contemporary context is no longer acceptable. Notwithstanding, it stands to reason that colonial systems remain intact and dysalignment persists. Dysalignment can only be addressed through realignment - the reorganization of structural accountabilities towards new outcomes. Colonial systems remain intact, never having gone through a true realignment process across pentad partners.
Dysalignment is not only a colonial problem. All health systems become dysaligned over time, with the entrenchment of special interests that leverage structural accountabilities – results of negotiations with physicians and nurses are one example. There are ongoing efforts within health systems to realign through centralization, regionalization, legislation, etc.

More resources in dysaligned Indigenous health systems intensify dysalignment, further feeding a cycle of more frequent and intense crises. As the outputs of dysalignment accumulate, perpetual crisis forces patients/First Nations/community within the inner circle towards activities that force the outer circle into realignment. Escalation can be grouped into four broad activities; media, political action, civil unrest and litigation. Entrenched special interests within the outer circle resist realignment through de-escalation activities that provide small improvements in side-conversations, resource allocation and outside implementation but never lead to realignment – the reorganization of structural accountabilities towards new outcomes. Realignment is reconciliation. Reconciliation inevitably leads to health transformation.

Three policy choices arise from the ALGIN model:

1. De-escalation, the current system response to dysalignment. Effective de-escalation depends on suppression of the truth or de-legitimization of truth-tellers. The long struggle of residential school survivors to share their legitimate stories was a direct result of effective de-escalation. De-escalation maintains the status quo. The status quo and perpetual crisis is no longer tenable for patients/First Nations and their communities are forced towards realignment. Currently, the government is pushing for the destruction of residential school materials to re-suppress the truth of the residential school experience. This is all to maintain the status quo.

2. Escalation. This will advance until it overwhelms de-escalation and forces realignment/reconciliation. The class-action lawsuit of residential school survivors forced reconciliation through litigation. Effective reconciliation rarely results from escalation. Escalation presents the greatest risk to pentad partners, including health leaders and their respective health systems; as escalation advances, health leaders and health systems will become a target for litigation for example.

3. Reconciliation, the voluntary decision to realign systems towards new structural accountabilities and outcomes. True reconciliation is the best balance of risk/benefit/cost and always occurs rapidly. Reconciliation does not require involvement of all pentad partners simultaneously, it requires a willingness to fully engage in truth-telling and realignment.

It is important for health leaders to choose their policy choice, instead of having that choice thrust upon them. Making no choice or a choice to incrementally change structural accountability maintains the status quo and its undesirable outcomes.
Background document provided by Joe Gallagher, Chief Executive Officer, First Nations Health Authority

First Nations Health Authority Profile

The First Nations Health Authority (FNHA) is one of four components of a unique governance structure established by and for BC First Nations. This governance structure was established through a consensus-building process amongst BC First Nations leadership, culminating in the largest-ever collective exercise of First Nations governance authorities in BC. The governance structure was further enabled through a health partnership amongst BC First Nations, the Province of British Columbia (BC) and the Government of Canada described in a series of legal and political health plans and agreements beginning in 2006.

Health Governance

The First Nations health governance structure includes four component entities: 1) a First Nations Health Council, responsible for political accountability, advocacy, and leadership; 2) a First Nations Health Directors Association – a professional association for community-based health service administrators; 3) the FNHA, responsible for the design, delivery and funding of First Nations health services and partnering to improve the quality of provincial services accessed by First Nations in BC; and, 4) a Tripartite Committee on First Nations Health (TCFNH) composed of federal, provincial and First Nations health leaders responsible for overseeing progress in implementing improvements to health services accessed by First Nations in BC.

Progress is largely achieved through agreements and agendas for improvement amongst health organizations that participate at TCFNH. The FNHA has executive agendas developed with the Ministry of Health and Health Canada which describe annual priorities for health system improvement, the growth of the health partnership, and which provide direction to bilateral forums and committee processes amongst each party’s senior executive teams. Similarly, a series of Partnership Accords between First Nations, the FNHA and the province’s Health Authorities describe joint priorities, initiatives, and targets for improvement to health governance, health planning, and health service delivery.

All of these health governance processes are enabled by the principle of reciprocal accountability. This principle recognizes that although a set of shared goals and commitments exists, the organizations involved in the health partnership each have different capacities and roles to play. Each organization is responsible to ensure that their part of the health system is functioning in a manner that supports the shared goals and commitments, and mutually reinforces the activities of others involved. The principle of reciprocal accountability looks different at each level and forum, meaning that the type of work done to advance shared commitments is different at a political level, from a policy-making level, from the senior operational level, and from the front-line service delivery level. It is through the effective deployment of the different component elements and levels of the health system that progress will be achieved towards common goals.

First Nations Perspective on Health & Wellness

The Centre Circle: Wellness starts with individuals taking responsibility for our own health and wellness.

The Second Circle illustrates the importance of Mental, Emotional, Spiritual and Physical facets of a healthy, well, and balanced life.

The Third Circle represents the overarching values that support and uphold wellness.

The Fourth Circle depicts the people that surround us and the places from which we come.

The Fifth Circle depicts the determinants of our health and well-being.

The people who make up the Outer Circle are the individuals, families and communities the FNHA serves.
Strategic Policy and Information

A key component of the FNHA’s unique mandate is its role as a health and wellness policy organization and policy partner to federal and provincial governments. The FNHA approaches this role from the First Nations Perspective on Health and Wellness, seeking to champion holistic and upstream thinking and approaches in our health systems policy, research, and information, and through partnering with policy-makers and influencers. Some key examples of this role in practice:

- Development of FNHA Policy Statement on Cultural Safety & Humility, describing the organization’s philosophy of health literacy as a two-way conversation and learning opportunity.
- Creation of new wellness indicators in partnership with the Provincial Health Officer, moving from only deficit-based indicators to those which support a strengths-based conversation.
- Establishment of Research Chair in Heart Health with Simon Fraser University and St. Paul’s Hospital, and a Research Chair in Cancer and Wellness with the University of British Columbia – dedicated capacity to undertake research into First Nations priorities, from a First Nations worldview.

Quality Agenda

The FNHA is also a health service planning, delivery, and funding organization. A founding purpose of the First Nations health governance structure is to achieve improved quality of health programs and services utilized by First Nations in BC. To advance this purpose, the FNHA has established a Quality Agenda which reflects the FNHA’s unique multi-faceted mandate by organizing quality improvement areas and activities along three perspectives of the FNHA’s service mandate. A number of improvements have been achieved and are underway, with cultural safety as a common thread across the three perspectives.

Perspective 1: Provincial Services

Engaging the broader system and advocating for First Nations interests to receive culturally safe services.

Examples:

- Declarations on Cultural Safety & Humility have been signed with the Ministry of Health and Health Authorities as well as with 23 Health Regulators, including commitments to action plans.
- Resolving jurisdictional and policy barriers to timely and equitable access to services between First Nations on-reserve and other British Columbians.

Perspective 2: FNHA Services

Ensuring First Nation customer-owners receive culturally safe and quality care from FNHA delivered services.

Examples:

- Creating FNHA service standards aligned to the First Nations Perspective on Health and Wellness and which outline the quality of services that our clients can expect to receive from the FNHA in key services areas such as Health Benefits; Nursing; and Environmental Public Health.
- Establishing a complaints process to support the quality of all health services accessed by First Nations in BC.
- Investing in “Primary Health Care++” services that places the individual, family and community at the center of care, ensuring comprehensive and culturally safe services.
centre, supported by wrap-around layers of care inclusive of primary health care, traditional wellness, oral health, and mental health and wellness integrated with upstream public health and wellness services and tertiary and quaternary care systems.

Perspective 3. FNHA Funded Community Services

Promoting Quality and Cultural Safety through FNHA funded and supported community services. Examples:

- Supporting the capacity of Health Directors to champion cultural safety and humility and quality.
- Streamlining and supporting meaningfulness and relevance in community planning, reporting and evaluation in alignment with the First Nations Perspective on Health and Wellness.

Background document provided by Dr. Nadine Caron, Co-Director, UBC Centre for Excellence in Indigenous Health

A Canadian Responsibility: Turning Stories into Action

The number one motion selected last year at the 2016 Great Canadian Healthcare Debate was: “Resolved that, health care leaders commit to addressing widening health inequities and quality of care of First Nations, Métis and Inuit patients by working to implement the recommendations of the Truth and Reconciliation Calls to Action for Health; beginning with recommendation 19...and establish a coordinated strategy for the Calls to Action, in partnership with Indigenous Peoples, in the next three years.”

This choice signified that leaders in health care were ready to both commence this movement towards reconciliation with Canada’s Indigenous peoples where there was none, and advance initiatives that were currently underway. Most participants agreed that the egregious health disparities rooted in our country’s history must be our #1 priority to address. With the Truth and Reconciliation Commission report and subsequent Calls to Action, we are in a unique position to have directives that emerged from the voices of Indigenous peoples who shared their stories and gave us glimpses of truths embedded in our nation’s history.

The Truth and Reconciliation Commission of Canada (TRC) was established in 2008 as a result of the Indian Residential Schools Settlement Agreement (IRSSA), the largest class action settlement in Canadian history. The TRC reviewed thousands of documents and heard from hundreds of witnesses at national events across Canada. Its final report contained an executive summary with 94 “Calls to Action” which cover broad themes including child welfare, education, language and culture, health and justice. These “Calls to Action” are aimed at redressing the legacy of residential schools and advancing the process of Canadian reconciliation.

The TRC Calls to Action specific to Health include numbers 18 through to 24 but recognizing the impact of history on current statistics, health care, and the broader social determinants of health, it must be acknowledged that all 94 Actions will benefit the health and wellness of Indigenous people and their communities.

As a First Nations health care provider, researcher, and professor, I see the TRC as a tool to be carried in our back pockets to remind ourselves what must be accomplished, and to highlight that no one person, department, or government has the authority to establish barricades or barriers to impede its progress. Indeed, we need to create a national movement where the responsibility on the pages of the TRC report is carried by all those who have the authority to make it happen, those who can support such movement, and those who must advocate for change. Two Calls to Action have particular applicability to post-secondary institutions who train our future health care providers (HCP) and who are inextricably linked to the health professions that their trainees enter, their faculty are part of, and the health of our nation relies on.
These are TRC Calls to Action #23 and #24.

**TRC #23:**

*We call upon all levels of government to:*

1. *Increase the number of Aboriginal professionals working in the health-care field.*
2. *Ensure the retention of Aboriginal health-care providers in Aboriginal communities.*
3. *Provide cultural competency training for all health-care professionals.*

By increasing the number of Aboriginal professionals in the HC field, we will address: a) the inequities in access to the spectrum of education in Canada for Indigenous peoples, b) the paucity of Aboriginals in the health care system and subsequent lack of voice in this profession and the clinical guidelines, health care priorities, leadership positions that currently exist, c) the lack of HCP in Aboriginal communities (including rural and remote Canada that have overlapping challenges), d) the minimal access to Aboriginal HCP who likely bring associated cultural safety and humility to the health care environment for patients, family members and communities alike.

By establishing strategies to ensure the retention of Aboriginal HCP in Aboriginal communities, we will address access and utilization of health care services in Indigenous communities. We will also highlight the isolation and expectations upon Aboriginal HCP that should be acknowledged and addressed within the health system and health education planning.

Cultural “competency” demand has now shifted to expectations of cultural safety and humility. While it is a significant undertaking to include *all health care providers*, this Action will be accompanied by vital impacts that are long overdue. It includes those who completed training in their health care profession with the expectation that they were taught all the tools needed to provide the health care in their niche. Why add something previously absent from curriculum, competencies, and examinations? It may seem like a logical question until we look at any other area of health care and continuing professional development (CPD). CPD and the responsibilities associated with it evolve and improve the quality of health care we provide for all Canadians – including Indigenous Peoples on- reserve, off-reserve, rural or urban, north or south.

**TRC #24**

*We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.*

Since it was released publically in 2015, the TRC has inspired discussions and dialogue about who should create this curriculum or where to get it, how to put this curriculum into a packed course load, and how to evaluate it. The question that arguably brings the most tension to a room is, “why?” There is a range of perspectives with resulting slow, often ambiguous movement for this Action. This Action needs to be addressed urgently and, with the impact of time, is being amended to include all health care trainees. With patient-centered care focusing on the patient and not on the HCP, the concept of multi-disciplinary care being adapted and the roles of HCP being adjusted, it makes sense for this to apply to all those in the health-care arena (not just medical and nursing students). Just as with any program being implemented, the evaluation is a vital part – on multiple levels - including the trainee, the school, and the impact at patient and system levels.

The TRC has placed the education of Canadians at its foundation – including professionals and trainees in health care. Post-secondary institutions are an integral part of this. We must move forward to determine how we can play a role as leaders in health care in Canada to ensure that we are part of the solution to implement the next steps to TRC 23 and 24.
Appendix A: Truth and Reconciliation Commission - Health Related Recommendations

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:
   i. Increase the number of Aboriginal professionals working in the health-care field.
   ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
   iii. Provide cultural competency training for all healthcare professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

55. We call upon all levels of government to provide annual reports or any current data requested by the National Council for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to:
   i. The number of Aboriginal children—including Métis and Inuit children—in care, compared with non-Aboriginal children, the reasons for apprehension, and the total spending on preventive and care services by child-welfare agencies.
   ii. Comparative funding for the education of First Nations children on and off reserves.
   iii. The educational and income attainments of Aboriginal peoples in Canada compared with non-Aboriginal people.
   iv. Progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
   v. Progress on eliminating the overrepresentation of Aboriginal children in youth custody over the next decade.
   vi. Progress on reducing the rate of criminal victimization of Aboriginal people, including data related to homicide and family violence victimization and other crimes.
   vii. Progress on reducing the overrepresentation of Aboriginal people in the justice and correctional systems.