Long Term Evaluation of the Health Transfer Initiative: Major findings

Rick Browning, M.S.W.
Adje van de Sande, D.S.W.

Introduction

This article summarizes the major findings of the Long Term Evaluation of the Health Transfer Initiative, the initiative of the Medical Services Branch of Health Canada to transfer control of health services and budgets to First Nations Communities. The study was conducted by the Institute for Human Resource Development for Medical Services Branch.

The main focus of the long term evaluation was to assess the overall success of the Transfer Initiative in facilitating community control, and its impact on the health of Indian people. It should be noted that assessing the direct impact of Transfer on the health of Native people was difficult to measure at this time. Changes in health status are generally the result of a number of factors and occur over the long term. Furthermore, management information systems (MIS) are not in place in all transferred communities and those where MIS do exist have not been in place long enough to measure the direct impact of the programs on the health status of the members of the community.

The three primary areas of study in this evaluation were: whether or not Transfer achieved its objectives; the impacts and effects of Transfer; and identification of alternatives to the Transfer process.

The research issues and questions posed in the study considered the positive and negative impacts of the Transfer Initiative on both First Nation communities and Medical Services Branch of Health Canada in terms of: the organization and function of Health Canada; long term effects on services; health care delivery; and, health conditions at the community level.

Background

The Transfer Initiative was launched by the Minister of Health and Welfare in 1986, in response to demands from communities for greater control of health resources. The basic framework for Transfer was developed by the Sub-Committee on the Transfer of Health Services to Indian Control which included representatives of Medical Services Branch (MSB) and First Nations. In 1988, the Department of National Health and Welfare received cabinet approval to transfer the control of health services to native communities, south of the 60th parallel. On June 29, 1989 Treasury Board approved the financial authorities and resources to support pre-transfer planning activities to March 31, 1994, and to fund community health management structures under transfer agreements on a continuing basis.

The Transfer initiative was launched with the recognition that there was a wide range of experience and expertise on the part of First Nations communities involved in the provision of health services. Typically, larger communities close to large urban centres are much further along in the provision of health services and have well developed and well run programs. More remote communities have much less experience delivering these services. These communities rely heavily on Health Canada.

In 1989, Treasury Board also approved an evaluation strategy for the Transfer Initiative which would examine how well Transfer operated as a means of turning over control of health services to Indian communities. This evaluation strategy also included the requirement for both a short and a long term evaluation of the Transfer process managed by a joint advisory committee of First Nations and Departmental representatives, and regular (3-5 year) evaluations of the effectiveness of community health programs by Transferred communities.

The short term evaluation of the Transfer Initiative was completed by Adrian Gibbons and Associates in January 1992, also under the general direction of a joint First Nations/Departmental Advisory Committee. A smaller group from this Advisory Committee was subsequently struck to monitor the action taken by MSB on the recommendations emanating out of this evaluation.

There were a number of significant principles governing the implementation of Transfer, as outlined in the Memorandum of

Understanding between the Minister of Health and Welfare and Treasury Board, that required a process that would:

- Operate within current legislation
- Be optional and available to communities within provincial boundaries
- Permit health program control to be taken on at a pace determined by community needs, interest and management capacity
- Include resources for community health programs currently delivered by Health and Welfare, with the exception of Non-Insured Health Services
- Enable communities to design health programs to meet their needs and to allocate funds according to community health priorities, provided mandatory program requirements are met, and capital funds are used for capital purposes only
- Provide resources for ongoing health management structures at the community level
- Permit multi-year agreements (not exceeding five years) subject to annual appropriations, with defined methods of annual price and volume adjustments
- Allow communities to retain unspent balances for health-related purposes, and place on communities the responsibility to eliminate deficits
- Transfer to communities all moveable capital assets associated with operating the health services included in the Transfer arrangement
- Require annual comprehensive financial and program audits, and schedule evaluation of the Transfer process at specified intervals
- Implement new financial and program mechanisms to discharge accountability of Chiefs and Council to the community, Chiefs and Council to the Minister of NHW and the Minister of NHW to Parliament for responsible financial management and overall program results
- Provide a mechanism for intervention in the event of a health emergency or of the inability of a community to meet its financial or health program commitments

Methodology for the Evaluation

The methodology used for the long term evaluation involved two information gathering phases. The first was a review of the relevant literature and background material, as well as an initial phone survey with all communities in pre-transfer planning and all transferred communities. The focus of this survey was the extent to which the Transfer Initiative was achieving its goal of "transferring responsibility of health programs to First Nations and Inuit communities."

At the start of this evaluation, there were: 47 projects in the pre-transfer planning phase; 43 projects that had entered transfer; and 29 projects that were inactive, i.e., projects that at one time had entered the pre-transfer planning process but had subsequently withdrew. This was a total of 119 projects (some projects included Tribal Councils) that included 316 communities. The evaluators phoned each project up to a maximum of three times to arrange the phone interview. If after the third attempt, contact was not made with the key informant, no further attempts were made. The initial phone survey made contact with 39 of 47 (82.9%) projects in pre-transfer planning and 37 of 43 (86%) of those transferred.

The second information gathering phase was more detailed and involved: a phone survey with a sample group of communities in pre-transfer planning (23 of the 47–with a contact rate of 87%) and inactive communities (13 of 29–with a contact rate of 57%); on site visits were made to 22 of the 43 (100% were visited) transferred communities where case studies were conducted involving key informant interviews and focus groups; and interviews with key persons in Medical Services Branch at headquarters, region and zone levels, as well as representatives with First Nations organizations with a direct involvement in native health issues.

Limitations

The analysis of the background material, the phone surveys and the case studies form the basis of this report. Because of the nature of the questions as set down in the Terms of Reference, the study does not lend itself to quantifiable analysis in any systematic manner. As a result, the analysis reflected in the report is primarily a synthesis of the qualitative information collected.

Because of the diversity of questions and the range of issues, much of the information is kept at a general level of discussion. There are a number of areas that could be the focus of more in-depth studies, e.g., utilization rates, impact of pre-transfer planning phase, as well as Non-Insured Health Benefits (NIHB). Non-Insured Health Benefits include those benefits or services which are not normally provided by medicare. An example of NIHB would be the transportation costs related to medical appointments. Furthermore, many of the issues are specific to a region or even a particular community.

Many of the communities that are in pre-transfer planning or the initial stage of Transfer implementation are still very much absorbed with the operational issues. As a result, it was difficult for communities to explore alternatives to the transfer process as a means of taking control of their health programs. This involves a major shift in their thinking about Transfer.

Pre-transfer Planning Issues

The pre-transfer planning period is the foundation of Transfer. It is a critical period for communities to address the key issues of the Health Transfer initiative. This planning period not only helps communities understand the scope of the issues related to taking control of their health programs, but also to specifically define the health issues of their community and develop a strategy of how to address them.

Initially, communities that had experienced the opportunity to participate in training, community development and consciousness raising activities under the old structure were better prepared to understand some of the issues and implications for Transfer. They understood that transferring health programs can be a complicated process.

As the process evolved over the past five years, communities that experienced early successes became models for other communities to explore Transfer as a viable option. To some extent, there is a formal and informal communication network between communities, and this has been influential for new First Nations entering the Transfer process. This communication network has much more potential to provide a range of services in the future, e.g., second and third level services in particular.

The role of Medical Services Branch regional and zone staff

have played important roles throughout the Transfer process, particularly at the pre-transfer planning stage. It is important that MSB regional and zone staff are committed to the goals of Transfer and are aware of the issues related to Transfer Agreements. Regional staff are the key link for communities understanding the Transfer initiative and facilitating the planning process.

Barriers

Of concern to MSB is the amount of money and the time frames that are being paid to the pre-transfer planning stage. The communities are suggesting that, while it is an important period in the Transfer process, the expectations necessary to accomplish during the two year planning period are unrealistic. It is difficult to predict how much time a given community will need to prepare for Transfer. Remote communities with little direct experience in running health services may need several years to prepare. An examination of the expectations, time frames and cost need to be reviewed by both MSB and the First Nations.

There are regions where the concern over the recognition of Treaty Rights and their impact in the Transfer Initiative have created barriers to transfer negotiations. In these regions, MSB and First Nations will need to continue to strive to find alternative strategies that will help them move beyond this impasse.

Two important reasons contributing to communities discontinuing in the Transfer process are: difficulties in accessing qualified staff particularly in remote northern communities; and, the issue of fiduciary obligations and other of the government to provide health care, and other concerns related to Treaty Rights.

As communities evolve into Transfer, they are able to integrate holistic methods of delivery. For instance, some communities which are relatively advanced in the transfer process have well integrated service structures that include health and social services. These services take into account the physical, emotional, social, and spiritual needs of the community. At the early pre-transfer phase, considerable emphasis is focussed on operational issues and communities becoming oriented to Transfer. As communities become familiar with running their own programs and recognize the flexibility that exists, they gradually integrate culturally relevant methods of delivery. There is a need to find a way to integrate holistic approaches

at the front end of the process and help communities understand the scope and latitude, as well as the flexibility, that Transfer has.

Three areas that require further attention in terms of resources and strategies are: management development training, computer training, and development of Management Information Systems. There are few well developed training plans or strategies in place either at the Medical Services Branch regional level or in the communities. Administrators need training in various aspects of management, including intra and inter-organizational communications and electronic data recording, in order to provide the best services for their communities.

Training is also needed in the areas of policy and procedure development, in a manner which is culturally appropriate for First Nations Communities. Those communities more familiar with Transfer have learned to develop policies and procedures that are culturally appropriate and take into account the needs and priorities of the community. Those less familiar need help with the process of policy development.

Throughout the collection of information for this study, communities consistently supported the relevance of mandatory programs and acknowledged their importance in providing for the public health and safety of all on-reserve members. There have been concerns by some communities in their abilities to deliver certain programs and services, particularly Environmental Health Services, development of Emergency Response Plans, and for some, a Medical Officer of Health.

Changes at the Community Level

The majority of communities are emphasizing the movement toward promotion and prevention programs that place responsibility for health care on the individual. There is more emphasis on treatment in isolated communities which are responsible for delivering all primary medical services.

As the anticipated changes of the decision of MSB to move out of health care delivery becomes a reality, more and more communities will be attempting to understand the residual role of MSB and how they provide second and third level services. First level services are those services provided by the communities while the second and third level services are those provided by the zone and the

region respectively. Examples of second and third level services are Environmental Health Services, Medical Officer of Health Services, and Professional Nursing Supervision. The residual role of MSB involves those services which are not included in the Transfer Agreements.

One of the changes that is causing concern at the community level is the decision by the Federal government to cap the overall growth rate in spending by Medical Services Branch. This will have an impact on such services as the Non-Insured Health Benefits (NIHB), such as medication or transportation costs of getting people from remote areas to appointments for medical care, benefits not normally covered by medicare. Until now, NIHB have been covered by MSB. Negotiations are under way to include NIHB in the transfer, but these expenses are substantial and communities are concerned about having enough resources to cover these costs.

First Nations health authorities are aware of the need to ensure that members of bands are informed of health care issues and have input in the design and delivery of programs. There is an increased recognition that health is a community-based issue. One of the important roles of community health boards is their ability to provide the link between community members and the health authority.

All communities report an increased use of health programs and services. Most bands reported that frequent users of the programs and services were: children between 0 to 4 (pre-natal, neo-natal care, "chronics" with needs for ongoing care and/or medication, immunization); majority of elders; and most women during their fertility years. Few young people or middle-aged men access services. Potential users are in the area of home care.

The majority of communities reported that in their perception, the negotiation of terms, conditions and resources was not a consistent process. Some communities were concerned that there was no sharing of information with other bands around specific agreements. This lack of information led to a perception on the part of some communities that agreements were negotiated differently with different communities.

It is recognized that having flexibility in the negotiating process in being able to respond to individual community needs and still maintain an equitable process is difficult. If benchmarks are introduced and agreements become more formulated, it may be that the

perception of inequity will be reduced, but the flexibility to negotiate agreements based on community needs may also be reduced.

It was recognized by both Medical Services Branch regional offices and First Nations, that MSB is understaffed and does not have the time to properly receive and analyse reports and information that communities are expected to send to MSB as part of their requirements. While it appears that many communities do want a substantive relationship with MSB in terms of validating their expertise, they note that if MSB has legitimate expectations, it is important for MSB to respect these requirements and give communities feedback.

The most important element in the pre-transfer planning phase is the Community Health Plan. Staff training is also considered to be an important element of the Transfer process. Of concern are the remote northern communities where a training strategy may need to incorporate distance education models. Such strategies may need to account for upgrading, ongoing staff development, and specific skills development necessary to deliver comprehensive health services in isolated communities.

Many positive impacts have resulted from the Transfer process. They include an increased community awareness of health issues and a greater opportunity for communities to take control of their own health care programs. The most pressing issue confronting communities and MSB at this point are the shifting roles of MSB particularly at the regional level which pertains to the delivery of second and third level services.

This is an area of real concern and uncertainty for both First Nations and MSB. There is an overall increase in Non-Insured Health Benefits for all First Nation communities. At the same time, preliminary examination of data from NIHB would suggest that nationally the cost per capita for communities that are under a Transfer Agreement are significantly less than those communities that are not. Further analysis of this information will need to be made in order to draw any conclusions about these trends.

First Nations view Transfer as part of the continuum toward self-government. They believe that communities should eventually have full ownership of their health care programs and services, and that Medical Services Branch take on the role of banker and, to some extent, broker of certain residual services. While MSB will need to maintain its accountability role, over time First Nation structures will

need to be established in order to take over certain areas of responsibility that are now solely in the hands of MSB. One of the most important issues confronting MSB and First Nations is being able to clearly define the residual roles of MSB, particularly in relations to second and third level services.

Discussion

In order to understand whether the goal of Transfer has been realized, it is necessary to look closely at the Transfer process and the way in which communities are being phased into taking responsibility and control of their health programs. Some communities entering the Transfer process and in the pre-transfer planning phase are ambivalent as to whether or not they are ready to take control of their own health programs. This has resulted in different kinds of relationships between communities and regions. Some communities become somewhat dependent on MSB to direct them through the pre-transfer planning stage which leads to frustration. This relationship of dependency results in communities feeling stuck and fearful of taking risks in advancing their health agendas.

The majority of Transferred communities, however, are expressing a greater level of confidence in wanting to take over more responsibility for health care. In particular, they are demanding to be more involved in policy formulation, as opposed to consultation. Communities need to have more involvement in policy formulation if there is to be a real Transfer of authority to First Nations, as opposed to only the Transfer of service administration.

One of the important goals of Transfer was to improve the communities' capacity to manage their own health programs and services. It was assumed that if management capacity improved, community health status would also improve. Here again, those communities more familiar with Transfer have developed their management capacity to include: implementation of policies and procedures, administration of budgets, planning, hiring and supervision of staff.

The Transfer Initiative is a lengthy and complex process. The process involves the transfer of responsibility for health from a large government bureaucracy, which is being dismantled, to new bureaucracies, which are still in their infancy. In spite of a commitment from both sides to see the Transfer process succeed, numerous unforseen obstacles are appearing regularly. The government as well as First Nations communities must understand that this shift in responsibility will take patience and understanding.

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NISHNAABE KINOOMAADWIN
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