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Transforming First Nations Health Care in British Columbia: An Organizational Challenge

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Abstract

Following a series of agreements on First Nations health care in British Columbia beginning in 2005, several organizations were created to contribute to the development of a system of health care for First Nations in the province, with the aim of transforming First Nations health care to better meet users' needs. This article considers the role of these organizations and their relationships with the provincial government, the federal government, and the First Nations people of British Columbia. It explores possible levels of transformation, as well as the possibilities and problems for these organizations in undertaking the transformation process, particularly with regard to their position on the boundary between the worlds of First Nations and Canada. It also considers sources of, and threats to, their legitimacy in this undertaking. Finally, wider points of relevance beyond British Columbia are identified.

Keywords

boundary, British Columbia, Canada, First Nations, health care, legitimacy, organizations, transformation

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Transforming First Nations Health Care in British Columbia: An Organizational Challenge

This article discusses a group of organizations created in 2005 to provide and regulate health care for First Nations in British Columbia. I will view these organizations in the context of the decolonization of Indigenous health and health care, and I will argue that this process of decolonization requires a redefinition of the terrain of Indigenous health by personnel and organizations with the legitimacy to do so. I will identify relevant questions at political, organizational, and policy levels, and I will also consider the aforementioned organizations in relation to their development, structure, and relationships, and to issues related to legitimacy and effectiveness in this task of redefinition. Although the context of my discussion is British Columbia, these considerations can apply to Indigenous health care in the rest of Canada and also to some degree in the US, Australia, and New Zealand, as those countries have similar histories of colonization of Indigenous Peoples, pursuing comparable processes of health care reconfiguration. As Indigenous Peoples develop political structures to work toward self-government, health care organizations necessarily play a role in this process, and the work of decolonizing will fall in part on them. The developments in British Columbian health care organizations exemplify this process.

Literature Review

Unlike most other Canadians, whose health care is controlled by provincial governments, First Nations health care has historically been the responsibility of Canada's federal government. Many commentators argue that First Nations' health care is inferior to that of other Canadians in several ways (Boyer, 2004; Health Council of Canada, 2005, 2012; Romanow, 2002). One problem is under-resourcing. First Nations are a growing segment of Canada's population, with many living in remote areas that are expensive to serve, and rigid funding mechanisms fail to adapt to these needs (see Lavoie & Forget, 2006). There are also problems of cultural insensitivity and racism, manifesting in negative assumptions about First Nation patients, which lead to a failure to achieve trust and cultural safety in health care (Health Council of Canada, 2012). First Nations cultural perspectives on health are distinctive, diverse, and complex, but generally include a view of health as collective, communal, and environmental, and as permeated with spirituality (Levesque, Li, & Bohemier, 2013); a valuing of Indigenous healing traditions; an emphasis on the health benefits of cultural vitality (Gehl & Ross, 2013); and a distinctive view of health decision making (Gomes, Leon, & Brown, 2013), health research, and knowledge (Barwin, Crighton, Shawande, & Veronis, 2013; Hernandez, 2012). The Health Council of Canada (2012) argued that the devaluing of these perspectives in the health care system has a negative impact on the quality of First Nations health care.

It is difficult to establish how much damage poor health care does to a community's health, compared with other factors. On average, First Nations have poorer health than other Canadians (Health Canada, 2009, 2014), but health inequality is also associated with deficits in housing, education, economic conditions, and social relationships (Mikkonen & Raphael, 2010; Wilkinson & Pickett, 2010). Economic inequality and social exclusion, through experiences of mistrust and powerlessness, seem to have a particularly significant impact for First Nations. Similar problems affect Indigenous Peoples throughout the world (Pulver et al., 2010) and are perhaps best understood as products of colonialism.

The transfer of health care to First Nations themselves is widely seen as a solution to the shortcomings of federal provision (Waldram, Herring, & Kue Young, 2006). Since the 1980s, reacting against the earlier policy of assimilation, the policy of First Nations health transfer has involved the allocation of some health care functions from the federal government to individual First Nation organizations (Lavoie & Dwyer, 2016). The mix of functions has varied from nation to nation—from comprehensive primary care through to public health to specific programs such as diabetes care (Warry, 2009). In some cases, this has involved greater participation by provincial health ministries, as in British Columbia, where regional health authorities have sought closer coordination with First Nations health initiatives at the instigation of the provincial health ministry. Again, this process is mirrored in other countries with Indigenous populations (Dwyer, O'Donnell, Lavoie, Marlina, & Sullivan, 2009) including New Zealand and Australia (Panaretto, Wenitong, Button, & Ring, 2014).

The Canadian health care transfer process has been uneven, suffering from funding and organizational problems; however, the potential benefits are recognized in principle by several commentators including Smith and Lavoie (2008), Waldram et al. (2006), and Warry (2009). There are also notable instances of health care transfer improving the cultural sensitivity of care (Kelm, 2004; Smith & Lavoie, 2008; Warry, 2009). However, the impact on health indices is difficult to quantify. At their time of writing, Waldram et al. (2006) still awaited quantitative evidence that transfer was improving First Nations health. In its 2014 *Statistical Profile of the Health of First Nations*, Health Canada (2014) found that between 2002 to 2003 and 2008 to 2010 there was no change in some indices and deterioration in others, though most indices were not comparable between the two time periods. The evidence is inconclusive. However, given that the quality of care is only one of several factors affecting population health, the effects of care improvement are likely to take some years to show.

New Organizations

Beginning in 2005, a series of agreements involving the federal government of Canada, the provincial government of British Columbia, and several First Nations organizations at the band, national, and provincial levels formulated a set of principles for the development of First Nations health care in British Columbia. Part of the impetus for this came from the 2005 Kelowna Accord, wherein federal and provincial governments and Indigenous representatives attempted to reshape the relationship between Canada and its Indigenous Peoples (Alcantara & Spicer, 2016). Federal interest in the Kelowna process faded, but some provinces retained momentum, and this energized health care development in British Columbia. A group of health care bodies eventually emerged from the British Columbia process, including the First Nations Health Council (hereinafter the Council), a representative body of 15 members set up in 2005 with members appointed by regional caucuses representing First Nations in the five health regions of British Columbia; and the First Nations Health Directors Association (hereinafter the Association), consisting of directors of First Nations health care providers. This collaboration culminated in the 2011 Tripartite Framework Agreement between the aforementioned First Nations organizations, the federal government, and the government of British Columbia (First Nations Health Authority, 2011). This agreement established the First Nations Health Authority (hereinafter the Authority) as the health care provider. Initially, members of the Council (though acting as members of the Authority) appointed the Authority's board of directors and the board of directors in turn appointed the Authority's management. In setting up the Authority, the Tripartite Agreement completed the group of organizations and committed the federal and provincial governments to finance the enterprise (First

Nations Health Authority, 2011). In 2013, the Authority started to take over health programs from the federal government (First Nations Health Authority, 2014), while First Nations regional health and wellness plans were developed in each of the five health regions of British Columbia. This took place under the auspices of the Council, as well as local and regional bodies representing First Nation communities. These plans elaborated the principles mapped out by the Council since 2005, summarized in its “[Seven Directives](#)” (First Nations Health Authority, n.d.), and began to translate these directives into commitments and practices. However, negotiating a complex and innovative set of relationships between disparate organizations and groups proved a slow process.

As Kelly (2011) pointed out, these developments are part of a history of health care initiatives that have sought to move from pre-1970 assimilationism into what she terms “policies of recognition” (p. 1), including the federal government’s Indian Health Policy of 1979 and the 1980s Indian Health Transfer Policy. This latter policy laid the foundations of a “targeted parallel” (p. 6) system of First Nations health care—that is, a system that targets the needs of a particular minority by substituting focused services for mainstream ones (Lavoie, 2014). Lavoie’s classification is adapted from Healy and McKee (2004), who distinguish the targeted parallel system from targeted alternative services (which target minority needs alongside mainstream services) and from non-targeted universal services. Part of the context of this development is the historic aspiration of Canada’s First Nations to political self-determination. Significantly, the Tripartite Framework Agreement declares that its terms shall not prejudice self-determination for individual First Nations (First Nations Health Authority, 2011). Otherwise, presumably, the already-established Tripartite health care system could cut across individual First Nations self-governance arrangements. Nonetheless, the Authority, the Council, and the Association clearly have a potential role in First Nations self-determination, through their potential political clout and professional credibility. The investment of political capital in these bodies by government and First Nations opens a window of opportunity for political influence within the Tripartite machinery and in the politics of British Columbia health care. The Tripartite Agreement places the Authority below the provincial health ministry level, on a par with the province’s five health authorities, in a provider rather than a political role. But political linkage to the Council, the Association, and the Tripartite Committee connects it to the provincial and federal health ministries, and this provides a potential conduit for political influence.

It is not yet clear where political and philosophical leadership will come from within this group of organizations. The Council is identified as the political actor (First Nations Health Authority & First Nations Health Council, 2013; First Nations Health Authority, First Nations Health Council, & First Nations Health Directors Association, 2012). It conducted the negotiation with the federal and provincial governments, and it may continue to provide political leadership in tandem with the Association—with the Authority in a subordinate position planning and delivering health care. However, the documentation de-emphasizes hierarchy in their dealings with one another, instead emphasizing mutuality, negotiation, and consensus; as a result, power relations are somewhat unclear to the outside reader. Nonetheless, an alternative scenario is imaginable, where increasingly politicized professionals and managers in the Authority propel their organization to develop its own political agenda. Of the other political forces involved, no doubt the provincial and federal health ministries will continue to exert influence through the supervisory function of the Tripartite Committee, as paymasters of the new system (First Nations Health Authority, 2011). In addition, the regional caucuses will create a bottom-up input into the Authority through their regional health and wellness plans, developed over

the last 2 years. The five regional plans express allegiance to the goals of the Tripartite Framework and the Seven Directives (First Nations Health Authority, n.d.), but the detail of regional priorities varies, and the Authority will need to balance these to retain the support of the caucuses. Despite the emphasis on collaboration, there is a possibility of tension developing between the Authority and its partners. Differences in occupational culture and day-to-day political pressures could encourage diverging goals, though much will depend on the flexibility and creativity of senior personnel. The balance of leadership is not yet clear. My discussion will therefore relate to all three bodies together—Authority, Council, and Association—to avoid assumptions about who will take the lead. Throughout this article, I will refer to “the Trio” rather than name all three organizations.

My discussion of these bodies is informed by an overview of relevant documents from the period under discussion (2010-2015). These are listed in the Appendix and include annual reports of the Authority, Council, and Tripartite Committee, published agreements between the bodies in the Tripartite Agreement, plans, updates, summaries, the Authority’s Guidebook, and health and wellness plans published by the regional tables of the Council. This overview aims to capture the main sources of information, but does not purport to be systematic or exhaustive. A first reading of the documents generated questions, and a second reading was initiated within that framework of questions concerning the relationships between the organizations, their conceptions of their enterprise as embodied in the questions outlined below, and their conception of their accountability and legitimacy in the management and delivery of health care.

Working on the Boundary

The Trio operate in two worlds: The First Nations world, defined and constituted by the experiences of First Nations in Canada and the Canadian world of health care politics. The Trio inhabit a boundary. Since the development of the boundary concept in ethnic relations in the 1960s (Barth, 1998), it has been applied to interactions between ethnic, cultural, and national groups. According to Barth, the boundary constitutes the zone where two cultural worlds interface; where those worlds are mutually identifiable and reinforced, but also interact. The boundary concept applies particularly to groups in constant, close contact, so it works well for the relationship between First Nations and Canada. For example, Poliandri (2011) used the concept of the boundary in her study of the relationship between a Mi’kmaq reserve community and the surrounding Nova Scotia town. She found that the boundary varies in visibility and permeability, being in different contexts including the psychological, social, geographic, and political. Health care can be a boundary zone, as illustrated by Mattingley (2006). In her study, White-dominated medical culture interfaced with the culture of African American patients, but this could also apply to the relationship between White-dominated health care culture and First Nations. Moreover, the Trio are boundary organizations themselves. They are Canadian health care agencies, linked to the health ministries of British Columbia and Canada, and they need to maintain a working relationship with these bodies; however, they are also First Nations organizations in their moral responsibility and formal remit. As a result, they need to manage the boundary, particularly its permeability, in both directions and on several levels. For instance, the Trio will be working on the boundary between First Nations conceptions of health and health care, and Canadian conceptions—a boundary similar to that described by Mattingley (2006). They will need to decide how they manage that boundary, and where it will run through their activities. For example, they will need to decide in

which situations Indigenous-healing traditions will be involved, and in which roles appropriate practitioners will be engaged.

At the organizational and political level, the Trio will also need to decide how to make the boundary permeable in the “outgoing” direction by deciding to what degree they will project professional and political influence across that boundary. They will need to decide how they present themselves to British Columbia’s political class and public, and how they project their agenda into the wider Canadian discourse. Their effectiveness in this could crucially affect their overall success, not least in terms of the resources they will likely need from across the boundary. They will also need to decide what allies to seek across the boundary, among the political class, and what friends to seek within the population. There may be an opportunity to transform the terms of discussion of First Nations health matters, using cross-boundary links to promote First Nations principles, terminology, and political traditions. This opportunity also makes it possible to contribute to the decolonization of Canada, a process envisioned by Macdonald (2013) as Indigenizing Canada’s political discourse. Shaping public perceptions is an important part of political practice, and its application to Canadian health care has been analyzed in terms of rhetoric by Conrad and Cudahy (2010), demonstrating the importance of framing the debate in a way that validates one’s case and connects with clearly targeted audiences. This is a resource-heavy process (think tanks, foundations, journals, etc.) and friends on the other side of the boundary could be crucial for mobilizing resources and identifying receptive audiences. The boundary role might also involve acting as a filter in the “incoming” direction. The profitability of health care in North America attracts commercial providers, seeking to exploit the more profitable parts of Canadian health care (Angell, 2008), and these providers generally have a vested interest in doctor-dominated, pharmaceutically focused health care with minimal cultural sensitivity. For First Nations health care, the Trio may be the only significant countervailing force, being potentially the holders of a uniquely powerful moral high ground that, if used skilfully, could restrain commercial expansionism.

Mapping and Transformation

In order to manage the boundary effectively, the Trio will need to have a clear overview of what the First Nations side of the boundary looks like. They will need to map the First Nations health world, with their version of health care mapped onto it. This has already been acknowledged implicitly, as *The Guidebook* (First Nations Health Authority & First Nations Health Council, 2013) predicts a shift in the process of transfer of health care from federal to First Nations organizations, from “transition” to “transformation,” wherein health care will be transformed to reflect First Nations perspectives. This is likely to take several years. However, in developing their political machinery, a cadre of leaders and managers, and in running their complex and demanding arm of government activity on a province-wide scale, they could in due course make a significant contribution to First Nations self-determination.

The planning period from 2005 has involved much discussion of the principles upon which First Nations health care should be based (First Nations Health Authority & First Nations Health Council, 2013). These are presented in the Trio’s documents as reflecting a consensus within British Columbia First Nations; in their breadth and inclusiveness, the principles certainly suggest a commitment to achieving consensus. However, their breadth will also require interpretation into more specific medium- and long-term choices, and that interpretation will involve considerable intellectual and political work, including the identification of underpinning principles at several levels, if it is to achieve clarity and

consistency. The transition and transformation agenda offers an opportunity to redraw First Nations health care from first principles. The possibilities of transformation, explored through a first reading of the documents listed in the Appendix, resolve themselves into choices at five levels, which I explore below.

a. The Meaning of Health

The most fundamental level of transformation concerns the meaning of health for First Nations in British Columbia. Questions include:

- What are the definitional boundaries of health as a good, and how is health to be distinguished from other goods such as education, physical skill, stamina, happiness, well-being, and spirituality?
- Is health an individual or a collective good?
- What is the moral and proprietorial relationship of health to those who enjoy or seek it? Is it a gift, a right, a commodity, or a virtue?

Addressing these questions would provide a base for the development of the other levels of the system. A view of health and health care that reflects First Nations experience provides the basis of legitimacy for the system, and the Trio will need to establish what they reject and what they retain of Western philosophizing on health and health care (see for example Seedhouse, 2001), Western medical epistemology (see for example Khushf, 2013), and where to replace these principles with concepts from First Nations philosophies of health (see for example Levesque et al., 2013; Robbins & Dewar, 2011) and Indigenous perspectives on epistemology (see for example Hernandez, 2012). An inclusive First Nations view might be achievable here. If it is not, multiple perspectives may need to be built into the system.

b. Health Care Provision as Part of the Polity

The next level addresses the principles upon which the provision of health care becomes part of the First Nations polity. These relate to issues posed by commentators such as Weinstock (2011). The overarching question here might be: How should health care provision relate to the general obligations binding First Nations as a political community? And that question generates further questions:

- Should First Nations claim a significant part of the resourcing of First Nations health care from Canada? If so, should the claim be for health care resources:
 - As a fiduciary treaty-based obligation (Boyer, 2004)?
 - As restitution for colonization?
 - As a benefit equally available to all citizens (Wilmot, 2014)?

- How should the relative requirements of just distribution of resources on the one hand and justice in the recognition of identity (including past denials of identity) on the other be balanced (Fraser, 1995)?
- What is the appropriate balance between health care as an expression of solidarity within the community, and health care as a vehicle of collective self-determination?
- How far can collective self-determination in health care accommodate individual self-determination (Napoleon, 2005)?
- Should First Nations health care seek to achieve justice between present and future generations on, for instance, the 7-generation principle (Horn-Miller, 2013)?¹
- Should First Nations health care provide:
 - A safety net to guarantee basic protection against the personal, social, and economic disruption inflicted by sickness for every member of the community?
 - A level playing field for people to pursue their individual interests, in accordance with Daniels's fair equality of opportunity (Daniels, 1985; Rawls, 1971)?²
- Should First Nations health care aim to redistribute resources within the community? For example, should it, through provision of health care based on progressive taxation, shift resources from people who are better off to those who are worse off?
- Should users be passive recipients of communal resources, as in the modern welfare state liberal view; individuals with responsibility for self-provision, as under a classical liberal framework (Gaus, Courland, & Schmitz, 2014); or citizens with responsibility to contribute to the polity and its activities, as in the civic republican view (Honohan, 2002)?

c. The Distribution of Choice and Responsibility Within the System

This level of exploration would require decisions on:

- Who should choose what particular mix (or mixes) of health care provision to provide, and to whom to provide it?
- How much freedom providers should have in choosing what mixes of health care they offer?
- How much freedom users should have in choosing which mixes of health care they access?

¹ A principle of the Kahnawa:ke Nation that collective decision-making should take into account the assessed impact of a decision seven generations into the future.

² A principle developed by John Rawls (1971, and applied by Norman Daniels (1985), that in a competitive society people should have a "level playing field" not skewed by health or educational disadvantage.

- Who should pay what proportion of the cost and through what process?

So, would a single program be available for everyone? Would choice operate entirely through democratic accountability, or entirely through the market, or somewhere in between? Health care systems within advanced economies show many different balances of public, voluntary, and commercial provision, putting power of choice in different places, to be exercised in different ways, collectively or individually, with different locations for the tasks and incentives of providing (see for instance Reid, 2010). In our case, there may be reasons to locate responsibility with certain institutions—for instance, at the community level in a decentralized structure or in smaller units in medical savings accounts as described by Cherry (2012). In these choices, the Trio will need to apply the principles decided under heading (a) above.

d. The Individual Service-Users' Entitlement

The ground-level questions arising from (a) to (c) concern the individual service-users' entitlement. This would ideally require a consensus on what constitutes a just distribution of resources. Distributive justice, as a branch of Western moral philosophy, can aid decisions on the relative importance of the principles of equality, utility, rights, need, and deserving (Butler, 1999), but a further judgement on the relative weight of these and other principles in the context of First Nations traditions of moral determination would need to be made here. If general principles cannot be agreed upon, a just process of negotiating separate arrangements for different nations or communities espousing different principles would have to be achieved. An acceptable system of resource allocation and rationing is imperative for the credibility of the system.

e. How Decisions on (a) to (d) are Made

Finally, an agreement would be needed on decision-making procedures for the above four levels. In one scenario, a common health care program might be achieved through deliberation. In another, different nations or communities might have different preferences, with programs specific to those, possibly along the lines of Emanuel's "liberal communitarianism," wherein different communities with different values subscribe to different programs within a common system (Emanuel, 1991). The Trio will need to find a workable balance between the range of Indigenous models for political decision-making (Cornell, 2015; Horn-Miller, 2013) and the non-Indigenous approaches to this process as surveyed by Ham (1997) and Sabik and Lie (2008).

The above five areas identify the levels at which the transformation of First Nations health care can happen. Levels (a) and (b) seem to fall into the remit of the Council, though the input of the Authority is likely to become important here as its thinking develops. Level (c)—including the specific content of the health care program—appears to fall at least partly into the remit of the Authority. Levels (d) and (e) involve all participants.

Logic suggests starting with the most fundamental questions at levels (a) and (b), but the politics and psychology of that process risk an ungrounded and indecisive debate. Perhaps level (c), allowing a more concrete and decisive discussion, is a better starting point, later providing a platform for deeper debates at levels (a) and (b). Wherever it starts, level (e) must be addressed effectively. The legitimacy of the whole enterprise depends on decision-making structures and processes being acceptable to those

directly affected by the outcome, and those with the power to facilitate or derail the process. There will be demands on other resources, but a major demand will be on the vital resource of legitimacy.

Legitimacy, Accountability, and Governance

The Trio has as their constituents some of the most marginalized people in Canada, whose needs have been poorly served by previous organizations, which means the Trio would need to overcome that legacy in order to achieve legitimacy with their First Nations constituency. The Trio's relationships, internally and externally, are crucial to legitimacy and accountability. The principle of reciprocal accountability, which frames accountability as mutual rather than hierarchical, is cited as a guiding principle (First Nations Health Authority & First Nations Health Council, 2013). Judged in traditional organizational terms, the official documents (Appendix) define accountability between the Trio organizations somewhat ambiguously. This ambiguity is also acknowledged by Dwyer, Boulton, Lavoie, Tenbenschel, and Cumming (2014) in their overview of health care contracting for Indigenous Peoples in several countries. I would suggest that a rationale for this apparent ambiguity around accountability can be found in the principle of multilevel governance, developed as an alternative to traditional organizational hierarchies (Hooghe & Marks, 2001) to replace hierarchical accountability (lower bodies implementing the policies of higher bodies) with a system of negotiated collaboration between bodies at different levels in the hierarchy. In the view of Alcantara and Nelles (2013), multilevel governance underpins several organizational developments in the governance of Indigenous Peoples worldwide, typically involving a government-level body collaborating with non-governmental or quasi-governmental bodies. The formal hierarchy is de-emphasized in the relationship between these bodies, and principles of co-operation and shared accountability guide the process of governance, with decisions being made through negotiation.

Papillon (2011) explained the attraction of multilevel governance in the Canadian context as a response to the inability of Canada's constitutional traditions to accommodate Indigenous self-government. He argued that Canada, unlike the US, does not view First Nations as having pre-existing sovereignty, and consequently the Canadian state has consistently resisted sovereignty and self-government claims. He suggests that multilevel governance provides a way of circumventing these constitutional roadblocks by allowing the development of organizational relationships operating to non-hierarchical principles. It provides a better account of the Trio's roles than traditional governance principles, and the ambiguity in accountability (in traditional administrative terms) reflects its principles. In addition, multilevel governance fits with the boundary situation discussed in the third section of this article. Its emphasis on negotiated relationships and non-hierarchical transactions provides the flexibility for organizations to co-operate across the kind of boundary discussed there. However, this approach to accountability also raises questions about legitimacy. The legitimacy of organizations can be viewed in three dimensions: input, output, and throughput.

Input Legitimacy

Input legitimacy, as discussed by Boedeltje and Cornips (2004) and Borrás, Koutalakis, and Wendler (2007) concerns an organization's links to sources of legitimacy, including democratic institutions and the community it exists to serve. For the Trio, two relationships are relevant: the relationship with democratic institutions such as the provincial assembly and federal parliament, and the relationship with

the First Nations community. The Trio are all relatively new bodies, and their links to the established structure of the Canadian state—through the provincial and federal health ministries—are based on the Tripartite Agreement, which, according to their espoused model of reciprocal accountability, connects them laterally rather than hierarchically. Their flexible, negotiated, multiple-level, and cross-boundary relationships seem to reflect the multilevel governance principle. They certainly do not fit comfortably within the traditional view of legitimacy, which tends to be conferred hierarchically.

As for links to the First Nations population, the Authority has no representative structure, and it can only derive input legitimacy from linked organizations. Within the Trio, the Council might provide that link, being nation-based, community-oriented, and representing British Columbia's First Nations on several levels from nation governments through regional caucuses to a central council. But whatever input legitimacy the Council has, it is not clear how much it can transmit to the Authority. It is difficult to find a clear documented account of the formal relationship between the two and, again in keeping with multilevel governance, the process of the relationship seems to be clearer than its structure. However, clarity and stability in the relationship are vital for input legitimacy, and they depend on structure. A lack of clarity in organizational relationships threatens input legitimacy. That lack of clarity can be attributed in part to the cross-boundary role of the Trio, in that their organizational relationships have developed across the First Nations–Canada boundary, so First Nations as yet have neither a clear organizational structure setting them apart from provincial and federal ministries, nor a readily identifiable process connecting them. The resulting vagueness in the relationship between these bodies, Canadian and First Nations, limits the Trio's input legitimacy.

Output Legitimacy

Output legitimacy is identified by Boedeltje and Cornips (2004) and also by Mena and Palazzo (2012), and it concerns the degree to which the organization's output is valued and trusted by those who confer legitimacy. In this case, those who confer legitimacy are the user population, the Canadian state, and the Canadian public. Several authorities have suggested that Canadians see their health care system as a significant component of the Canadian national identity (Rachlis, 2001; Romanow, 2012) and a First Nations health care system might reasonably aspire to be similarly valued by its users. However, where a new health care system has high hopes riding on it, there is a risk of disillusionment. If the new system fails to visibly ameliorate First Nations' health disadvantages, its output legitimacy may be compromised. Creating a new health care system is probably not the best way to tackle health inequality, which is typically associated with the determinants of health discussed earlier, including housing, education, economic conditions, social relationships, and socioeconomic inequality. As argued by Williams, Costa, Odunlami, and Mohammed (2008), interventions likewise need to be targeted to those "upstream" areas, which merit at least as much priority as the health care system. As these limitations start to become apparent to First Nations service users, there is a risk of popular disappointment and further discontent could arise from rationing decisions. Like other publicly funded health care bodies, the Authority will need to prioritize and ration resources. Some people will view certain decisions as unfair and these feelings will be intensified by disappointment that, after campaigning for the creation of a First Nations health care system, that body is providing inadequate care. This would threaten the output legitimacy of the Trio, both for individual First Nation service users and for participating nations, with a risk of inter-nation disagreement over resource allocation. The risk applies also with regard to Canadian governments, provincial and national, who will be looking for solutions, not political

embarrassment, and for Canadians in general, among whom such problems could serve to confirm colonial prejudices.

Again, the boundary is part of this problem. The Authority is inheriting part of Canada's health care machinery, and there will be a transition period during which some of that machinery will remain on the "wrong" side of the boundary in terms of personnel, methods, and working culture. Until service users see the Authority's service as part of the First Nations world, it is unlikely that service users will feel that it is their "own" health care system. Users often become frustrated with their health care system, but their sense of ownership of that system can create a bond protecting its legitimacy in difficult times. Arguably, this has happened in Canada, but the location of First Nations health care within the federal government system means that First Nations have not had ownership of their health care. That ownership needs to be built, and it will take time to become secure. Consequently, output legitimacy is at present not a firm basis for the Trio's work of transformation.

Throughput Legitimacy

Iusmen and Boswell (2016), Schmidt (2013), and van Meerkerk, Edelenbos, and Klijn (2015) all identify a third source of legitimacy, throughput legitimacy, which involves maximum consultation and involvement of service user populations by public bodies providing a service. This concept was developed for European Union (EU) organizations with complex and indirect accountability to democratic bodies. It provides a direct way to gain democratic accountability and legitimacy. The Trio is also characterized by complex and indirect accountability: internally in the link between the Council and the Authority, and externally in the Trio's relationship with the Tripartite Committee. These links do not show a clear path of accountability to democratic bodies such as the British Columbia provincial legislative assembly and the federal parliament and, as I suggested above, this weakens their input legitimacy. However, there is potential for throughput legitimacy. The Trio have the advantage of a clearly defined service user population who know who they are and who are already organized locally through Indigenous political institutions and leaders. Therefore, consulting that population should be easier than similar consultations undertaken by EU bodies, in that the protagonists in this dialogue will be operating on the same side of the boundary. Throughput consultation between service users and Authority personnel regarding what the First Nations version of health and health care should look like can be conducted according to First Nations norms, locating it on the First Nations side of the boundary. In addition, flexible, negotiated relationships (commended by the multilevel governance principle) can facilitate trust between participants and help service users tolerate shortcomings in provision. However, there are also risks. Some negotiation (where bargaining, deal making, and compromise are involved) is virtually impossible in public, as generations of politicians have discovered. The degree to which consultation can convert into negotiation is not clear. In their study of throughput legitimacy in EU institutions, Iusmen and Boswell (2016) argued that there may be a need for "backstairs negotiations" to achieve optimum legitimacy. They also report that consultation that is perceived as tokenistic can increase cynicism among participants, so weakening throughput legitimacy. Lastly, they conclude that such consultation processes can be disruptive of the ability of what they term the "technocratic" body (in our case the Authority) to perform its task.

How might these risks be avoided? The process of consultation will be demanding, and it will require the Trio to navigate the above risks while nonetheless keeping their momentum. If the Trio is to be

successful in transforming health care, they will need to achieve a close and equal relationship with the service user population. That equal relationship will involve thousands of conversations between service users and Trio personnel, and the Council alone could not sustain that degree of intensity and detail. Managers and professionals from the Authority would also need to be involved in conversations with members of First Nations. This has considerable implications for the way power is distributed in the Authority, in that service users will need to relate in a close and equal way to the personnel, who represent the Authority to them, to be fully involved in the transformation. For service users to take that conversation seriously, they will need to know that Authority personnel will listen and in turn will be listened to within the Authority. That requires a decentralized Authority with a listening culture and known and trusted local personnel, who are seen to be listened to, at the centre of the organization. The management structure of the Authority as presented to the outside world appears to offer the space for this to be realized. It simply needs to happen.

However, the Trio will still have a legitimacy problem across the boundary. The legacy of colonialism in Canada creates a legitimacy problem for any First Nations enterprise, as it will risk being perceived as inferior and exotic, and structures and outcomes (that is, input and output) may well be insufficient to overcome this perception. I suggested earlier that the Trio might choose to take the initiative in presenting their enterprise to the rest of Canada, perhaps using traditional and electronic (including social) media to frame the issues to their advantage. However, beyond political spin the Trio also has something authentic to offer to Canadian thinking about health care. Aspects of the five levels of transformation outlined earlier have been discussed several times in the history of Canadian health care, but the discussion has generally been inconclusive. As Canada's publicly funded single-payer health care system grew piecemeal, there was never an opportunity to think from first principles. Romanow's (2002) inquiry into Canadian health care, and the inquiry by the Senate Standing Committee on Social Affairs, Science and Technology (2002) in the same year, perhaps came closest to working from first principles. However, neither set of recommendations settled arguments about the appropriate direction for health care. Indigenous Peoples have generally been outsiders to this process, as their health care has been seen as a separate, marginal matter. But now First Nations are in a position to address these questions from a place closer to first principles than has previously been possible in Canada, and this process could reinvigorate health care thinking in the country as a whole. This is not part of the Trio's remit, but might well establish them in the Canadian context as important and legitimate players.

Conclusion

In this article, I have identified the creation of new organizations for First Nations health care in British Columbia (the Trio) as a step forward in First Nations health policy development. I have suggested that the internal politics within these bodies, as it takes shape, will be crucial to the development of the initiative. In addition, I have considered their boundary location and their transformational agenda in order to identify five focal levels of health care transformation. I have suggested that ambiguities in the Trio's accountability, though politically rational within the principle of multilevel governance, nonetheless raise legitimacy problems. I have identified the concept of throughput legitimacy as a potential strength for the Trio and have also suggested that the Trio could significantly influence the debate on Canadian health care. The main points from this discussion initially concern British Columbia, and do not all apply equally to other Canadian provinces and territories where the organization of health care varies. However, the shared basis of publicly funded health care provides

enough common ground to make much of this analysis applicable to the rest of Canada. There are also commonalities with other countries, particularly the US, Australia, and New Zealand. As Lavoie (2014) demonstrated, comparisons can be made with Scandinavia because of their Indigenous populations and similarities in terms of culture and society, particularly with Canada and New Zealand. Elsewhere, there is more diversity in the context in which health care is delivered and common ground diminishes.

For other Indigenous Peoples who want jurisdiction over service delivery, two recommendations can be made. First, all five levels of transformation discussed in the Mapping and Transformation section of this article are potentially relevant (though in diverse ways) to Indigenous Peoples in other developed countries. In addition, all five levels need to be addressed sooner or later, in any initiative comparable to the one in British Columbia. If any one area is neglected, it could eventually destabilize whatever system is developed. Second, legitimacy problems will likely affect Indigenous organizations in this situation. These require a double response: One to the Indigenous community, prioritizing relationship building at all levels in the organization in order to optimize throughput legitimacy, and the other to the surrounding state, proactively promoting the Indigenous initiative within the wider politics of health care. The latter offers a window to enhance the legitimacy of the relevant Indigenous institutions across the boundary.

For Indigenous bodies engaged in this process, I also offer two recommendations based on this article. First, commitment on all sides is needed to move toward clear lines of accountability to the Indigenous user population. Reciprocal accountability and multilevel governance are probably the right place to start; however, a more formal system needs to be a medium-term goal, providing long-term support for the institutions. Second, friends and allies across the boundary need to be identified and cultivated. It might be worth appointing senior personnel to focus full-time on this goal. Finally, to return to British Columbia, I recommend that the Tripartite Commission commission competent external bodies to monitor the initiative on at least the following four levels.

First, long-term transformation goals, reflecting the five transformation levels discussed, should be formulated, operationalized, and reviewed at 2- to 3-year intervals. Clearly, these are not all objective or quantifiable, and the fact that they include political and moral judgements needs to be publicly acknowledged and deliberated.

Second, First Nations health indices should be publicly monitored. However, this needs to be done in conjunction with data on social determinants of health in order to promote understanding of the relationships between determinants and health, and the Trio's contribution to this process is understood in context.

Third, Trio's performance should be regularly monitored using evaluations by service users.

Fourth, audits of the Tripartite system's decision-making processes should be made at 2- to 3-year intervals, focusing on different parts of the system, tracking decisions, identifying influences, and in particular monitoring the involvement of and responsiveness to users.

As this initiative develops, British Columbia's model for decolonizing health care will be tested. It has some way to go to establish its effectiveness within its own territory, or its relevance elsewhere.

Nevertheless, my thesis is that the British Columbia model has potential as a pathfinder. I have sought to cast some light on the path.

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