Alberta Doctors' Digest

Alberta health system refocusing's impact on First Nation, Inuit and Métis health

In recent years, Alberta's health care system has undergone a dramatic change. Since first being announced in October 2023, government has restructured our health system, dismantling Alberta Health Services into four provincial health agencies and corresponding health ministries. Instead of one entity, Alberta now has Primary Care Alberta, Acute Care Alberta, Assisted Living Alberta and Recovery Alberta, each with a mandate to address specific elements of care.

While these changes have created confusion within the entire health care system, and concerns about transitions of care and continuity of care, the refocusing has raised questions about the impact on Indigenous health and growing risks to First Nations, Inuit and Métis patients.

"Coming purely from a systems' theory perspective, before the refocusing, we in Alberta were not alone with challenges, but at least there were Indigenous health clinical pathways and administrative infrastructures and processes in place that front-line providers had available to them," explains Dr. Cassandra Felske-Durksen, an Otipemisiwak family physician and chair of the Indigenous Health Committee at the AMA. "Colleagues have shared with me that with the restructuring an ongoing process, it's hard to know how to navigate the system to get patients and families the culturally safe and medically necessary care. Patients have shared that they are left with a sense of chaos and fear of falling further through the cracks. They are aware of the 19-year mortality gap. The Just Culture and Quality Assurance models are being heavily relied upon, reflecting the systems impact – and those within it, front-line physicians and staff, seeking to close that gap."

How it worked previously

Before the health system restructuring, there were two main Indigenous health infrastructures. The first was the AHS Indigenous Wellness Core that supported all four of the five zones. North Zone already had a very well-established Indigenous health program that worked closely and collaboratively with the Indigenous Wellness Core. "They worked so well together that, from a front-line provider perspective, it seemed like one single infrastructure." Every zone had operational leads that had established relationships with the First Nations, Métis and urban Indigenous communities, organizations and services within those zones who sat at the same tables and used communication workbacks.

"Because those networks were established and nurtured, if there was a question or an emerging need, there was an opportunity for bi- or multi-directional communication," notes Dr. Felske-Durksen. "If an issue required a table, a committee or a task force, whatever was needed was worked towards being established."

The Indigenous Wellness Core also engaged at the provincial level with broader Alberta Health Services, Alberta Health and Indigenous Services Canada (ISC), recognizing

First Nations have tri-lateral agreements with the provincial and the federal governments. In addition, there was a provincial AHS Indigenous Wisdom Council, which provided Indigenous perspectives and voices to help guide AHS in creating culturally safe, relevant, and accessible health services.

How things work now

With the health system restructuring, many of those existing channels and processes have been absorbed under one of the new health pillars. In the summer of 2025, it was announced that the bulk of Indigenous health services would move under Primary Care Alberta, one of the four health agencies in the province. The remaining services are available through Acute Care Alberta.

While many of the previous services still exist within the system, including the Indigenous Wellness Core, Indigenous Hospital Support Services, and the Indigenous Support Line, knowing which agency is responsible for them, how they work together, or how to access them has been unclear to those who need them – patients, families, communities, and referring providers.

“Most patients will need to access care that crosses all four health organizations, but knowing what is available under each pillar and who to contact in each is daunting. This is true for all Albertans but is amplified for Indigenous Albertans, especially within the context of pre-existing barriers to access, jurisdictional considerations, increasing needs for specialty care and the life expectancy gap,” says Dr. Felske-Durksen.

Dr. Felske-Durksen has taken to drafting emails for colleagues to try to help them navigate the various services. “It’s a bit of a ‘Who's Who in the Zoo’ – at least how I understand it – email explaining the refocusing and where people are at. Some colleagues have asked me if I would put together a toolkit for medical and operational leads that would outline all of the changes, but it’s changing so frequently, it’s hard to keep up and I certainly do not wish to misrepresent. In real life, real front-line clinical practice colleagues have shared that they feel the Alberta refocused health care system is relying on individual providers to wayfind for the patients – which contributes to patient access issues and provider burnout, risking further perpetuating in-access cycles, unfortunately.”

Community impacts

Dr. Felske-Durksen worries that while the changes have been frustrating for health care professionals, they have also been worrying for many Indigenous communities. “I have heard that this re-focusing is landing more as a de-focusing. Who do the health directors call at a provincial level when there’s an issue like a measles outbreak? Or a community member who needs to move from acute care to long-term care close to their home Nation, Settlement or neighbourhood? It used to be that you could pick up the phone and talk to someone, a single point of contact, who could assist and follow across the entire continuum of care. The division of Indigenous health into two health authorities and four departments means the front-line relies heavily on communication and referral workflows that are still in development.”

These changes are deeply concerning for many communities. “The impact of this refocusing is already being felt at a community level,” says Shelly Gladue, the Health Authority Director with the Treaty 8 First Nations of Alberta. “I support the health directors at the Nation level, and normally, if they had concerns about accessing services for members of the Nation, they would be able to reach out to their contacts in AHS and ask questions. Whether at a zone level or provincial, they knew who to contact. Now, I'm hearing that there is a lot of uncertainty."

Gladue notes that while health directors have some idea of how to work with Primary Care Alberta, the other three pillars are more difficult to understand. "There are very different services within each pillar, and there's no clear understanding of the Indigenous health advocacy within each pillar. It's making it more difficult for those health directors to help assist, navigate and advocate, because now you have four different agencies to try to work through."

Referral processes are particularly challenging because one patient might need care across all of the pillars. "Say you have a patient who has mental health issues, but they are also experiencing a chronic disease that requires a surgical procedure. What does that referral process look like? Do they get a referral from their family doctor for three different agencies? It's making everything more complicated when what we need is a single point of entry," stresses Gladue.

What needs to change?

Dr. Felske-Durksen explains that things are functioning for now, but only because people working in the health care system are finding their own temporary workarounds. "While waiting for clinical communication and referral workflows to be developed and implemented, and quality assurance processes to follow due process, Indigenous Albertans are still accessing health care and require necessary medical assessments and interventions. This is why patient-centred care and people-first leadership is so effective."

"It is so hard to be human right now. From a neurobiological perspective, we are not hard-wired for uncertainty. The truth is that we do not have a lot of control over the changes that are happening, or their timeframes. As physicians, we are probably operating from our sympathetic nervous system way more than we realize – we are being forced deep into the shame shack. The system refocusing, privatization of health care, rapidly changing markets, AI and the geopolitical landscape all unfortunately have impacts on our direct clinical care and patient outcomes."

"I remain curious as to how the refocusing success will be measured, and whether that will include both public and private health care. What are the measures of success? Clearly Health Economics are identified measures. Performance measures are ubiquitous indicators, and I have heard from all involved in Indigenous health that the life expectancy gap is a critical measure. It would be an incredible proof of concept to see that gap decrease (keeping all methods and methodologies the same, of course). If it does not, or only continues to increase, then I wonder if a fulsome quality-specific systems review would be of benefit," stresses Dr. Felske-Durksen. "What happens if the Primary Care Alberta Indigenous Wellness Core does not have cross-organizational educational and quality assurance supports with the other three health organizations?"

Dr. Felske-Durksen notes that the passing of Bill 13, the Regulated Professions Neutrality Act, raises additional concerns, especially for Indigenous health. "It's hard to know how to assess health authority culture change from a systems theory framework perspective. How will the four health organizations' privileging and the CPSA's regulatory oversight of conduct align with CFPC and RCPSC accreditation standards and the CMA's code of conduct on cultural safety and Indigenous health? At a time when there is so much confusion and uncertainty in the health system, we need safeguards to ensure a people-first approach so that health equity and cultural competency for all are upheld, not weakened.”

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