



Our Story

The Made-in-BC Tripartite Health Transformation Journey

PRODUCED FOR THE ASSEMBLY OF FIRST NATIONS



GLOSSARY

ADM – Assistant Deputy Minister

AFN – Assembly of First Nations

ANTHC – Alaska Native Tribal Health Consortium.

ATHS – Alaska Tribal Health System – a network for the entire Alaska Native health care delivery system

BCAFN – the BC branch of the AFN. One of the parties to the First Nations Leadership Accord and member of the First Nations Leadership Council in BC

BIA – Bureau of Indian Affairs – Federal department in the US responsible for programs for Indians in the US

The Blueprint – First Nations Health Blueprint for British Columbia – produced in 2005 by the First Nations Leadership Council

DSTAC – Direct Service Tribes Advisory Committee – U.S. Committee for Tribes operating under Direct Service health

FNHA – First Nations Health Authority

FNHC – First Nations Health Council

FNHDA – First Nations Health Directors Association

FNHS – First Nations Health Society

FNIHB – First Nations Inuit Health Branch – part of Health Canada responsible for administering health to First Nations and Inuit people who qualify for health benefits

FNIHGC – First Nations Interim Health Governance Committee

FNLC – First Nations Leadership Council – Collective body of First Nations organizations in BC (UBCIC, BCAFN, FNS) who came together to push for improvements to policies and programs, and a new relationship with BC, and later with Canada

FNS – First Nations Summit – First Nations political organization in BC initially formed to interact with the BCTC and the treaty making process in BC. One of the three parties to the First Nations Leadership Accord and member of the First Nations Leadership Council

GLE – Government Letter of Expectations

Health Plans – Refers to the TCA: FNHP and the TFNHP collectively.

iFNHA – interim First Nations Health Authority

IHS – Indian Health Service – a branch of the US Department of Health and Human Services branch.

MOH – Ministry of Health

MSP – Medical Services Plan – BC government administered health insurance plan for British Columbians under ‘Medicare’

NIHB – Non-Insured Health Benefits – a program operated by Health Canada to provide health benefits to First Nations and Inuit citizens

ODST – Office of Direct Service Tribes, Alaska

OTSG – Office of Tribal Self Governance – part of IHS in the US

PHO – Provincial Health Officer

RAF – Reciprocal Accountability Framework

RHA – Regional Health Authorities

TCA: FNHP – Transformative Change Accord: First Nations Health Plan signed in 2006

TFNHP – Tripartite First Nations Health Plan signed in 2007.

TMT – Tripartite Management Team.

TSGAC – Tribal Self Governance Advisory Committee – a committee of Tribal representatives that provides advice to HIS and OTSG.

SDOH – Social Determinants of Health.

UBCIC – Union of BC Indian Chiefs – political organization of First Nations in BC. One of the three parties to the First Nations Leadership Accord and member of the First Nations Leadership Council.

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foreword

Grand Chief Doug Kelly

In 2011 BC First Nations voted to take control of First Nations health services, this is our story.



Parents want to create a better world for their children. Grandparents want to create a better world for their grandchildren. As individual citizens, or as individual communities, it is very difficult for us to make progress in changing the world. When we engage our neighbours, partners, and others and reach “One Mind, One Heart, and One Spirit”, we can change the world. When it comes to health, BC First Nations have come together to change the world.

Through the federal Health Transfer policy of 1987, First Nations communities began to accept the challenge of designing and delivering a better quality of care to their citizens. Through these efforts, First Nations leaders, Health Directors, and citizens developed a deep and abiding self-confidence that we could do a better job if we secured the authority, responsibility and resources to do more.



On March 17, 2005, our senior political organizations (Union of BC Indian Chiefs, First Nations Summit, and the BC Assembly of First Nations) inked a Leadership Accord and agreed to work together to resolve the outstanding land question and to improve the quality of life for our citizens. This unity of purpose and voice created space of the Province of BC and the Government of Canada to consider partnership with BC First Nations.

Chiefs, health leaders, and citizens know that we cannot improve the well-being of our peoples on our own. We know that we need the assistance of willing and healthy partners to work with us to change the world for our children and grandchildren. Since June 2006, we have been working with officials at all levels of government. From the Minister's office, through the Deputy Minister through to the caregivers – we have been engaging in a dialogue to achieve a meeting of the minds. We now have partnerships with Health Canada, the BC Ministry of Health Services, and each of the Regional Health Authorities. Soon we will have a Partnership Accord with the Provincial Health Services Authority. Our partners have shown us that they want to work with us, and to be

collectively accountable for improving the health status of First Nations and Aboriginal citizens in BC.

Through all of this work, amongst ourselves, or with our partners, we have always pursued ancestral teachings of learning to listen and listening to learn. We seek informed decisions and to keep our family together – we seek decisions by consensus. This discipline will keep our First Nations Health Authority grounded in our realities and working to make a better world for our children.

Our citizens, leaders, and caregivers understand that human beings make mistakes. We will acknowledge our mistakes, take action to make it right, and learn and grow together. When we work with partners, we understand that our partners will make mistakes. Together, we will work through the process of holding one another accountable. In a good way, we will find a way to make right those things that have gone wrong, and change the world.

Our Indigenous brothers and sisters in other parts of the world shared generously their stories and experiences from taking on healthcare delivery. Following their example, we want to share our story of the journey, how we navigated the currents of change, and how we keep “One heart, One Mind, and One Spirit” in doing this work. Through sharing our story, we hope that other First Nations and Indigenous people will learn from our work as they take up the challenge to taking on the responsibility for healthcare for their citizens.

Tseem Grand Chief Doug Kelly,
Chair, First Nations Health Council

Introduction

British Columbia (BC) First Nations peoples face unique challenges with the health system and health services. These challenges include the ongoing impacts of colonialism on First Nations communities and individuals, remoteness factors, jurisdictional barriers and gaps, and non-integration of health systems and health providers. These challenges make health care access difficult and contribute to the disparities in health outcomes between First Nations people and the rest of the population. The need to improve the health system for all First Nations of BC was a unifying factor for Chiefs, Leaders, communities and government partners.

Over the last several years, First Nations leadership have worked with the federal and provincial governments to take significant steps towards changing the way health care is delivered in to First Nations people in BC. The opportunity for change has come through building consensus amongst First Nations leadership, developing a new health



ROAD TO TELEGRAPH CREEK. REMOTENESS IS ONE OF THE FACTORS FIRST NATIONS FACE WHEN ACCESSING HEALTH CARE SERVICES. SOME FIRST NATIONS MUST TRANSIT HUNDREDS OF KILOMETRES OF UNPAVED ROADS TO ACCESS HEALTH SERVICES WHILE OTHERS REQUIRE AIR TRANSPORT.

partnership with government and other key players in the health system, and establishing the appropriate capacity and mechanisms for implementation of a shared agenda for the improvement of health services for BC First Nations. Coupled with the right timing and willing partners, these factors allowed for a 'perfect storm' of change to take place.





Those involved in this transformation of the health care system take pride in a process that is 'Community-Driven Nation-Based'. Through various community engagement mechanisms, First Nations are not just involved, but are guiding the process. It was a remarkable and historic undertaking to bring together all BC First Nation communities and leaders to focus on health. A first for Canada, the establishment of a First Nations Health Authority (FNHA) created by and for First Nations people signifies a new era in BC First Nations health governance and health system transformation.

"Our Story: The Made in BC Tripartite Health Transformation Process" tells the story of the journey that BC First Nations leadership undertook, the partnerships that were developed, and the agreements and processes used to achieve successes and consensus among the First Nations of BC. "Our Story" may help guide other First Nations peoples across Canada and Indigenous peoples around the world about the process, successes and outcomes that are changing our health system and the way we collectively define health.



1) Background: The Health Se

Ocean-going canoes at Ambleside beach in West Vancouver. The revival of the ocean-going canoe tradition on the coast is one example of connections between Nations that are continuing and evolving in recent years.

BC First Nations are recognized as being one of the most diverse Indigenous populations in Canada and the world. There are 203 First Nations communities in BC, spread over a vast area of land, with a wealth of languages, histories, cultural expressions, and traditions. This diversity is also reflected in political outlooks and approaches. A lack of treaties creates a unique situation amongst First Nations in Canada and is a key feature of BC First Nations political life. Like the rest of Canada a majority of BC First Nations live away from home (off-reserve).

Canada's Health System: Jurisdiction and Provision of Health Services

Jurisdictional Responsibilities

The *British North America Act* (1867–1975) (later the *Constitution Act, 1867*) made health care the primary jurisdiction of the provinces by putting the provinces in charge of hospitals, asylums, charities, charitable institutions, local and private matters, and property and civil rights (Sec. 92(7), 92(13), 92(16)) and at the same time gave the federal government power over “Indians and land reserved for Indians” (Sec. 91(24)) and health services for specific target populations including: First Nations on-reserve, Canadian forces and veterans, and inmates in federal penitentiaries.¹ Despite the stated responsibility to First Nations on reserve, the federal government has never acknowledged a legal obligation to provide health care services

and to facilitate reasonable access to health services without financial or other barriers.^{5”}

“Canada’s national health insurance program, often referred to as “Medicare,” is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Instead of having a single national plan, we have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Framed by the Canada Health Act, the principles governing our health care system are symbols of the underlying Canadian values of equity and solidarity.” Health Canada⁶

As demonstrated in the above breakdown, service delivery to First Nations in Canada is complex. Disputes over jurisdiction remain an ongoing issue for First Nations across Canada and efforts are being made to come up with creative solutions to address the jurisdictional complexities that exist.⁸ The

Services Context

to First Nations.² Not surprisingly, the lack of a clear legislative basis for First Nations health has created many challenges for First Nations.

In Canada, the current national health care system is publicly financed, and for the most part is a publicly delivered system under the umbrella of the *Canada Health Act*.^{3,4} The *Act’s* primary objective is to “protect, promote and restore the physical and mental well-being of the residents of Canada

health reforms currently taking place in BC represent a step toward addressing questions over jurisdiction.

Health Service Provision by the Federal Government to First Nations

Public health and health promotion services for Status Indians on-reserve are largely administered through Health Canada’s First Nations and Inuit Health Branch (FNIHB), which has eight regional offices across Canada.⁹

Under the Canada Health Act, the provinces and territories are required to deliver health care in accordance with governing principles:

1. Universality of coverage: the provinces have to cover 100 percent of their residents for hospital and physicians' services
2. Portability of coverage: the provinces have to cover their residents for care in other provinces at the rate that pertain in other provinces
3. Reasonable accessibility to services: the provinces are to ensure that services are 'reasonably accessible' and that financial charges or other barriers do not impede access.
4. Comprehensive services: the provinces are supposed to cover all 'medically necessary' services provided by doctors or within hospitals. Community services (e.g. home care) are not covered
5. Public Administration: the provinces have to administer their health insurance programs either themselves or through a body that is accountable to the provincial government.

While the regional offices deliver and administer programs and services, FNIHB headquarters sets the strategic direction through the Strategic Policy, Planning and Analysis Directorate (SPPA).¹⁰ Headquarters provides a whole range of strategic services to the regions who implement this direction.¹¹ In BC, FNIHB has a central office based in Vancouver with some small regional offices around the province, and is responsible for administering and funding programs to all First Nation communities in the Province of BC – some of these programs are targeted for the on-reserve First Nations community, while others are for all Status Indians in BC. On reserve¹² health care for many BC First Nations is mainly prevention-based, although some larger



Yousuf Ali, Regional Director, First Nations and Inuit Health Branch, BC Region. At Gathering Wisdom Forum 2009.

communities offer a range of primary care services. 41 percent of FNIHB-BC Region funding is allocated directly to First Nations through health transfer agreements.¹³ The federal government established its *Indian Health Transfer Policy* in 1988.¹⁴ This policy supports First Nations to enter into agreements with Health Canada to take greater control of health program responsibilities at the local level.¹⁵ This includes administration of the Non-Insured Health Benefits (NIHB) program, which provides coverage for some dental, pharmacare and patient travel.¹⁶

From a national perspective BC First Nations have taken advantage of health transfer more than any

other region. By 2012, 85 percent of BC First Nation communities are in some form of transfer¹⁷. This uptake of the health transfer option has provided BC First Nations with a level of understanding, expertise and staff capacity that has significantly enhanced their ability to take the next steps towards First Nations health governance.

Some have been skeptical of the benefits of the Indian Health Transfer Policy to First Nations, suggesting that the policy has served as a means for the federal government to distance itself from health care service provision under the guise of supporting community control and autonomy.¹⁸ Proponents of this view argue that evaluations of the health transfers have shown significant cost-shifting to First Nations with limited benefits at the community level.¹⁹ Despite these views, the policy continues to be an important mechanism for promoting First Nations control of health.

“The FNIHB Transfer Policy is a successful initiative that has fostered the development of the infrastructure required by First Nations to control their own health system.” First Nations Leadership Council²⁰

British Columbia’s Health System

Under the *Constitution Act*, 1982²¹ and the *Canada Health Act*, 1984,²² the provinces and territories of Canada have the primary responsibility of organizing and delivering health care services to all British Columbians, including First Nations and Aboriginal peoples in BC, regardless of residence.

The BC Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, cost effective and timely health services are available for all British Columbians.²³ The Ministry works with health authorities, health care providers, agencies and other organizations to guide and enhance the Province’s health services to ensure that British Columbians are supported in their efforts to maintain and improve their health.²⁴ The development of social policy, legislation and professional regulation, is one of the key functions of the Ministry; this is done through funding decisions, negotiations and bargaining, and through its accountability framework for health authorities and oversight of health professional regulatory bodies.²⁵

The following provides a breakdown of services delivered to First Nations:⁷

Provinces deliver hospital, physician and public health programs to all Canadians, including First Nations and Inuit, but, generally do not operate direct health services on-reserve.

Health Canada funds primary care in 85 remote/isolated First Nations communities, public health nursing, health promotion/disease prevention programming and environmental health services and home and community care in well over 600 communities.

Health Canada also provides eligible First Nations and Inuit, regardless of where they live with supplementary health benefits for certain medically required services where these individuals do not have coverage from other public or private programs (prescription drugs, medical supplies and equipment, dental care, vision care, short-term mental health crisis counselling and medical transportation).

First Nations and Inuit Communities and Agencies have taken on various levels of responsibility to direct, manage and deliver a range of federally funded health services.

Territories deliver insured health services and programs to all their citizens, including First Nations and Inuit. However, FNIHB provides additional funding for home and community care, and health promotion and disease prevention programs to First Nations (including those that are self-governing) and Inuit in the Territories. In the Yukon, FNIHB delivers the full NIHB program to eligible First Nations, whereas in the Northwest Territories and Nunavut, the program is delivered in partnership with the Territorial Governments.



Source: Prepared by BC Stats. July 2008. Retrieved August 9, 2012 from <http://www.bcstats.gov.bc.ca/Home.aspx>

The Ministry directly manages the Medical Services Plan, which covers most physician services; PharmaCare, which provides prescription drug insurance for British Columbians; the BC Vital Statistics Agency, which registers and reports on vital events such as a birth, death or marriage; and HealthLink BC, a confidential health information, advice and health navigation system available by telephone (8-1-1) or online (www.healthlinkbc.ca).²⁶ For example, the Province of BC is responsible for determining how many beds will be available in the province; determining how the system will serve the people of BC; approving hospital budgets; and

negotiating fee scales with the medical association and other health professional organizations.²⁷

The Province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions.²⁸ A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination and accessibility of services and province-wide health programs.²⁹ These include the specialized programs

and services that are provided through the following agencies: BC Cancer Agency; BC Centre for Disease Control; BC Children’s Hospital and Sunny Hill Health Centre for children; BC Women’s Hospital and Health Centre; BC Provincial Renal Agency; BC Transplant; Cardiac Services BC; the Emergency and Health Services Commission, which provides ambulance services across the province and oper-

ates BC Bedline, the provincial acute bed management system; BC Mental Health Addiction Services including Riverview Hospital and the Forensic Psychiatric Services Commission; and Perinatal Services BC.³⁰ .A Provincial Health Services Authority provides BC residents with access to a coordinated network of specialized health care services, such as cardiac care, transplants, and cancer.³¹



Aboriginal Health leads are in place for each of BC’s 6 health authorities, pictured here in 2009: Linda Day (Vancouver Coastal Health), Leslie Varley (Provincial Services Health Authority), and Leslie Bonshor (Fraser Health Authority).



2) Leadership: Establishing new

"I AM HERE BECAUSE I KNOW THE HEALTH AND WELLBEING OF THE PEOPLE I HAVE RESPONSIBILITY FOR DEPENDS ON HOW WELL I WORK WITH EACH AND EVERY ONE OF YOU IN THIS ROOM."

- Chief Douglas White III Kwulasuitun speaking at Gathering Wisdom IV in May of 2011.

Protocols among First Nations of BC

First Nations in BC enjoy long-established protocols for interacting with one another, protocols observed for hundreds of generations before contact with Europeans. These protocols have their origins deep in the past and have continued to evolve. Ceremonial, family and cultural customs continue to influence BC First Nations when they meet and, when linked with a shared history, common ground can often be found.

More recent developments such as provincial and regional-level First Nations political institutions and service organizations, as well as less formal inter-tribal community events, also serve to maintain links between First Nations. In addition, the shared history of colonization and the negative impacts it had on culture, and traditional social,

Treaties, Title and Rights

The matter of Aboriginal title and rights is an important feature of political life in BC. Some historic treaties exist, including the Douglas Treaties on Vancouver Island and Treaty 8 in the Northeast corner of BC, and are foundational documents for those First Nations and the Crown¹. The first modern treaty in BC was achieved by the Nisga'a in 1998. The BC Treaty Process was initiated in 1993 to resolve the outstanding land question in BC and after 20 years has resulted in two treaties: the Maa-nulth and Tsawwassen treaties. The majority of BC First Nations have not signed treaties or resolved outstanding issues of title, jurisdiction and self-government with the Crown. The outstanding 'land question' in BC is a key backdrop for political interactions between BC First Nations and governments.

v Relationships and Agreements

economic, and health systems are a common experience for many First Nations and Indigenous peoples across the globe, and provide the basis for collective approaches and dialogue. Abiding traditional established protocols has helped BC First Nations work through many difficult and complex issues and arrive at consensus, choosing to work together and speak as one voice.

key player

First Nations Leadership Council



A New Relationship amongst BC First Nations and with the Province of BC

In 2004, two important court cases involving First Nations of BC triggered a new relationship between the Province and First Nations: Haida Nation and Taku River Tlingit. These cases clarified the roles, responsibilities and duty of the Crown to consult and accommodate First Nations rights and titles to lands and resources affected by government decisions.

This monumental decision of the Courts created an opportunity to achieve real progress on First Nations title and rights issues. BC First Nations recognized that they would be able to take fullest advantage of this opportunity through unity amongst themselves. Leadership for this unity movement was provided by the three BC First Nations political organizations - for the BC Assembly of First Nations, then Regional Chief Shawn A-in-chut Atleo; for the First Nations Summit, Task Group members Grand Chief Edward John, Grand Chief Doug Kelly, and Dave Porter; and for the Union of BC Indian Chiefs, Grand Chief Stewart Phillip, Chief Robert Shintah, and Chief Mike Retasket.

On March 17, 2005, the three organizations penned the monumental *Leadership Accord*. The Accord affirmed mutual respect and formalized a cooperative working



The First Nations Leadership Council was formed in 2005 and is comprised of the political executive of the First Nations Summit, Union of BC Indian Chiefs and BC Assembly of First Nations. Its purpose is to generate political power through cooperation and collaboration between the existing provincial First Nations organizations.

relationship for political representation of the interests of First Nations in BC. It also committed to strategies and actions to bring about significant changes to government policy that will benefit all First Nations in BC. The UBCIC, BCFAN, and FNS formed a First Nations Leadership Council (FNLC) composed of the political executives of the three organizations to implement the ambitious agenda.

Concurrent to the development of the Leadership Accord, the Leadership Council was actively engaged in dialogue with BC on a range of issues and initiatives of common interest or concern among First Nations in BC, such as consultation and accommodation, national processes, social and economic programs and service issues.

This led to the release of the New Relationship document in May 2005. The New Relationship is a new government-to-government relationship based on respect, recognition, and accommodation of Aboriginal title and rights. It sets out a shared vision, goals and principles, and commits to action plans to establish processes and institutions for shared decision-making about lands and resources and for revenue and benefit sharing, and for the achievement of strong governments, social justice and economic self-sufficiency for First Nations.



Grand Chief Stewart Phillip, President, Union of BC Indian Chiefs. BC First Nations Tripartite Framework Agreement signing ceremony, October 13, 2011. Squamish territory.

"The journey that I've had the privilege to be part of in the last several years has been nothing short of incredible. When one thinks of the distance between our organizations, the animosities that existed, the bad feelings, the bad medicine and all those things that existed before 2005, March 17th when the leaders of our organizations came together and signed off on the (First Nations) Leadership Accord."

"For me it was a deeply personal moment because what motivated myself to be part of that historic moment was the fact that there were three young men in my home community in Penticton that were gunned down and killed as a result of a... war... vis-à-vis the drug trade. And I spent the most challenging month in my 36 years of involvement in the affairs of our people at home dealing with the trauma, the heartache that came along with that tragedy and witnessed the grief of the families and the children. And I knew in my heart at that moment that we do not have the luxury to continue squabbling and bickering and carrying on the way we did before the Leadership Accord in 2005."

"And so I knew that it was time, it was time to pick up the responsibilities that are part of the leadership and to rise above the partisan issues between our organizations and to take full responsibility for the health and well-being of our people."

- Grand Chief Stewart Phillip

The AFN-led National Health Blueprint Process

Parallel to the work of BC First Nations leadership, the Assembly of First Nations achieved 'A First Nations – Federal Crown Political Accord on the Recognition and Implementation of First Nations Governments.'² In 2005, the Assembly of First Nations (AFN) rolled out a Health Blueprint process across the country whereby regions would develop their own regional health blueprints describing regional health priorities that would be rolled into a national blueprint document on Aboriginal health.

The *First Nations Health Blueprint for British Columbia* (hereafter referred to as the *Blueprint*) was submitted to the AFN by the FNLC (July 15, 2005). A forum for BC's First Nations representatives provided detailed input into this *Blueprint* on June 22, 2005. BC leaders identified that there was a significant lack of access to existing services for First Nations people, especially in rural/remote areas. The leaders also cited limited access to health care for First Nations women – again particularly for those liv-

ing in rural communities. Another issue raised was a debilitating crisis in oral health resulting from limited access and financial barriers to dental care, as well as a serious gap in services in the mental health and addictions field including insufficient detoxification beds.

The BC *Blueprint* identified a new vision and approach for health service delivery and access that will contribute towards an improvement for BC First Nations overall health and well-being:

- Promoting health & well-being;
- Clarifying roles and responsibilities between governments and organizations;
- Sharing in improvements to Canadian health care;
- Developing ongoing collaborative working relationships; and
- Monitoring progress.

Establishing First Nations Health Plans and Agreements

The signing of the *Leadership Accord* charted a new course for political unity amongst BC First Nations. The *New Relationship* established common ground between First Nations and the Province to begin addressing the health and socio-economic gaps which existed for First Nations of BC. Finally, the AFN led *Health Blueprint process* completed in 2005 provided a roadmap to current health issues, challenges and priorities. These three foundational documents enabled the establishment of a series of health plans and agreements:

- Transformative Change Accord (November 25, 2005)
- Transformative Change Accord: First Nations Health Plan (November 26, 2006)
- Tripartite Memorandum of Understanding (November 27, 2006)
- Tripartite First Nations Health Plan (June 11, 2007)
- Tripartite Basis for a Framework Agreement on Health Governance (July 26, 2010)
- Tripartite Framework Agreement on First Nations Health Governance (October 13, 2011)

Throughout the rest of this document we reference the Tripartite First Nations Health Plan and Transformative Change Accord: First Nations Health Plan together as 'the Health Plans'.

Creating a New Administrative Arrangement for First Nations Health in BC - A Timeline



1980's

1975 US legislation enables American Indians and Alaska Natives negotiate first self-determination agreements

1990's

19 BC First Nations communities in transfer agreements
1990 First Health Transfer arrangements take effect in BC

1994 American Indians and Alaska Natives negotiate first self-determination agreements for health

2000

85 BC First Nations communities in transfer agreements

2002- Centralization and creation of 5 regional health authority's

2005

First Nations Leadership Accord

Transformative Change Accord

2006

Transformative Change Accord: First Nations Health Plan

Tripartite Memorandum of Understanding

2007

Tripartite First Nations Health Plan

First Nations Health Council is formed with representation from Union of BC Indian Chiefs, First Nations Summit and BC Assembly of First Nations

2008

Regional Caucuses meetings, formation of Caucuses

Inaugural meeting of the Provincial Committee on First Nations Health

2009

First Nations Health Society established

2010

Basis for a Framework Agreement
114 BC First Nations communities in transfer agreements

First Nations Health Council restructured to regional representation
First Nations Health Directors Association established

2011

Ratification by BC First Nations
Implementation Plan
Framework Agreement finalized and signed
First Nations Health Authority incorporated

Joint management of First Nations Inuit Health between First Nations and Canada (until a First Nations Health Authority takes over)

2012

Finalization of Framework sub-agreements

- Accommodation Agreement
- Record Transfer and Special Information Sharing Agreement
- IM/IT Transfer Agreement
- Human Resources Transfer Agreement
- Facilities Responsibilities Transfer Agreement

2013
&
beyond

Federal program and financial transfer to First Nations Health Authority

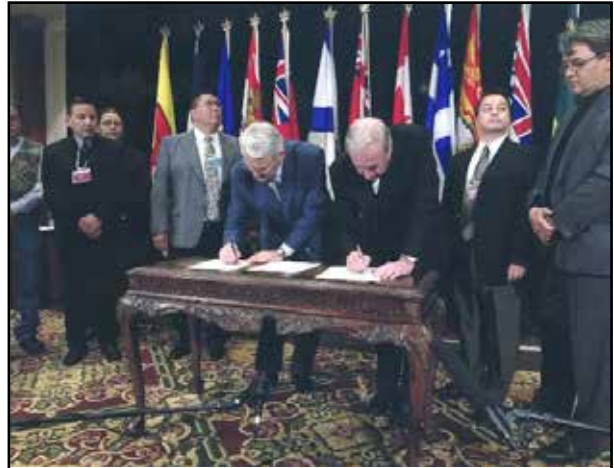
Ongoing First Nations Health Authority operations, program and service design and delivery

First Nations Health Authority begins operations

2005 Kelowna Accord

On November 24-25, 2005, then Prime Minister Paul Martin, Aboriginal leaders and the premiers from across Canada met in Kelowna BC for the First Ministers Meeting on Aboriginal Affairs³. At this meeting, the ministers and National Aboriginal leaders considered the *Blueprint on Aboriginal Health: A 10-Year Transformative Plan* for better results in the socio-economic conditions. These included: new relationships; education; health; housing and economic opportunities⁴. The agreement resulted from 18 months of roundtable consultations leading up to the meeting and outlined \$5 billion in spending over 10 years.

The meeting represented a significant political development and a public commitment to do a better job on the part of government and First Nations. The broad Kelowna Accord, titled *First Ministers and National Aboriginal Leaders: Strengthening Relationships and Closing the Gap*, set out a number of measures as well as an agreement to work together⁵. However, when the Paul Martin Liberal minority government fell and the Harper Conservative minority government came into power, the Kelowna Accord and its approaches were not supported by the



Signing the Transformative Change Accord in 2005 at Kelowna. Left to right – Chief Robert Shintah (UBCIC), Chief Mike Retasket (UBCIC), Grand Chief Stewart Phillip (UBCIC), Grand Chief Doug Kelly (FNS), BC Premier Gordon Campbell, Prime Minister Paul Martin, Regional Chief Shawn Atleo (BCAFN), Grand Chief Edward John (FNS).

new federal government, which wanted to take a different approach to the overall issues regarding Aboriginal People in Canada.

The Accord recognized the need to strengthen relationships on a government-to-government basis, and affirms the parties' commitment to achieve three goals:

1. Close the gaps between First Nations and other British Columbians in the areas of education, health, housing and economic opportunities over the next 10 years;
2. Reconcile Aboriginal rights and title with those of the Crown; and
3. Establish a new relationship based on mutual respect and recognition.

2005 Transformative Change Accord (TCA)

The Kelowna Accord was not the only document signed during the First Ministers meeting. During the meeting the Province of BC, the FNLC, and the Government of Canada signed a historic agreement entitled the Transformative Change Accord (November 27, 2005).

The Accord acknowledges and respects established and evolving jurisdictional and fiduciary relationships and responsibilities and the need to remove impediments to progress by establishing effective working relationships. Through the Accord, the parties agreed to establish a 10-year plan to bridge the differences in socio-economic outcomes.

key player Premier Gordon Campbell



"I CHARACTERIZED [THE KELOWNA ACCORD] AS CANADA'S 'MOMENT OF TRUTH'. . .IT WAS OUR CHANCE TO END THE DISPARITIES IN HEALTH, EDUCATION, HOUSING AND ECONOMIC OPPORTUNITY. ALL FIRST MINISTERS ROSE TO THAT MOMENT OF TRUTH ALONGSIDE CANADA'S ABORIGINAL LEADERS TO UNDERTAKE THAT CHALLENGE. HAVING MADE THAT EXTRAORDINARY NATIONAL COMMITMENT, ANY UNILATERAL REVERSAL WILL INVITE CONSEQUENCES THAT ONLY MAKE US POORER AS A NATION."

- Gordon Campbell, Premier of British Columbia, May 4, 2006.

Premier Gordon Campbell was not initially viewed as a friend of BC First Nations. The Liberal opposition to the Nisga'a Treaty, including a court action attempt to block it's passing into law, and a referendum on First Nations issues were both viewed as antagonistic actions that were politically opposed by most BC First Nations. The language and actions of the BC Liberal party in opposition were neither friendly nor conducive to dialogue and many BC First Nations considered Campbell as an adversary and were quite vocal about it.

Premier Campbell's relations with First Nations changed dramatically with the initiative to create a

New Relationship in 2005. The Premier and First Nations agreed to work towards Crown-First Nations reconciliation. Premier Gordon Campbell became a champion for advancing First Nations issues not only in BC, but amongst his colleagues across the country.

The change in policy and approach by Campbell has been cited as one of the major factors that allowed the relationship between First Nations and BC to positively progress and noted as a significant turning point allowing for a new relationship, discussions and agreements. The importance of his transformation cannot be overstated and it was with his support that major changes occurred.

2006 The Transformative Change Accord: First Nations Health Plan (TCA: FNHP)

The 2006 federal election resulted in a new Conservative government which distanced itself from *Kelowna Accord* commitments, including initially the signed *BC Transformative Change Accord*. Despite this, the Province of BC and the FNLC agreed to continue working on a bilateral plan focused on a key area of the *Transformative Change Accord* – health. The TCA: FNHP was developed between January and November of 2006, through a high-level political process drawing from the 10-Year Blueprint for Aboriginal Health, and the BC Provincial Health Officer’s report of 2001. The TCA: FNHP was released by the FNLC and the Province of BC on November 26, 2006. The 10-year plan included 29 action items in the following four areas:

**GOVERNANCE,
RELATIONSHIPS AND
ACCOUNTABILITY**

**HEALTH PROMOTION/
DISEASE AND INJURY
PREVENTION**

HEALTH SERVICES

PERFORMANCE TRACKING

“Last year we committed to close the health gaps between First Nations and non-First Nations over the next decade,” said Premier Gordon Campbell. “We know that First Nations people live an average of seven years less than other British Columbians and that their risks of developing health conditions like diabetes are also greater. The First Nations Health Plan sets into action this government’s commitments in the Transformative Change Accord to close the health gap between First Nations and other British Columbians. The first step was to get this plan in place.”

2006 First Nations Health Plan Memorandum of Understanding (MOU)

Although the federal government had distanced itself from *Kelowna Accord* commitments, it participated as an observer in the development of the bi-lateral TCA: FNHP and was encouraged by the progress made between the FNLC and the Province. Therefore, on November 27, 2012, the federal government, provincial government, and the FNLC signed a *First Nations Health Plan Memorandum of Understanding (MOU)*. This document included a federal commitment to the action items identified in the TCA: FNHP and proposed a number of new action items. It committed the federal government to work with the Province of BC and the FNLC to, based on the bilateral TCA: FNHP, develop a Tripartite First Nations Health Plan (TFNHP) within six months.



Premier Campbell and Grand Chief Stewart Phillip signing the MOU on First Nations Health



“The collective vision of the Province of BC, the Government of Canada and the First Nations Leadership Council is that the health and well-being of First Nations is improved, the gaps in health between First Nations people and other British Columbians are closed and First Nations are fully involved in decision-making regarding the health of their peoples.” (Tripartite First Nations Health Plan, 2007)

Signing of the Tripartite First Nations Health Plan. From left to right: Back row, left to right: Ian Potter - Health Canada; Dave Porter - First Nations Summit; Judith Sayers - First Nations Summit; Robert Shintah - Union of BC Indian Chiefs; Lynda Price - Union of BC Indian Chiefs; George Abbott - BC Minister of Health. Front row, left to right: Grand Chief Stewart Phillip - Union of BC Indian Chiefs; Tony Clement - Minister of Health; Grand Chief Edward John - First Nations Summit; Gordon Campbell - Premier of BC; Shawn Atleo - BC Assembly of First Nations Regional Chief.

2007 Tripartite First Nations Health Plan (TFNHP)

In February 2007 the First Nations Health Council (FNHC) was established, fulfilling one of the agreed-upon actions from the TCA: FNHP. A key deliverable of the tripartite First Nations Health Plan MOU was the development of a tripartite BC First Nations Health Plan by May 2007.

The TFNHP was to be informed by the Transformative Change Accord: First Nations Health Plan, and was to include additional action items designed to close the gaps in health. In order to successfully develop, complete, and implement the TFNHP, the First Nations Leadership Council, Province of BC and Health Canada agreed that discussions with First Nations communities and other health professionals must take place, and be an ongoing effort.

The First Nations Health Forum: Gathering Wisdom for a Shared Journey was the first dialogue session in pursuit of this important goal.

The forum brought First Nations leadership, health professionals, and health managers together with provincial and federal government officials to consider both the TCA: FNHP, and MOU and draft a plan for action.

On June 11, 2007, in Musqueam First Nation territory, the FNLC, BC and Canada signed the TFNHP. Through the Plan the parties committed to develop a new structure for BC First Nations health governance by 2010 – this structure would hold responsibility for regional health planning and

administration as well as health design, delivery and accountability to reflect the service delivery needs of First Nations. This structure was to be comprised of a number of essential elements including:

- A First Nations Health Governing Body
- A First Nations Health Council
- A Provincial Advisory Committee of First Nations Health, and
- A First Nations Health Directors Association.

Immediately following the signing of the TFNHP, the Parties commenced efforts to develop a workplan to describe how the TFNHP would be implemented. This work plan was completed on December 20, 2007 and covered all of the action items from the TCA: FNHP and additional actions. It also included a description of processes for implementation, such as the establishment of a Tripartite Management Team.

2010 British Columbia Tripartite First Nations Health Plan: Basis for a Framework Agreement on Health Governance (The Basis Agreement)

The TFNHP called for a plan for transfer of the design, management and delivery of federal health services to First Nations to a First Nations Governing Body to be developed within three years of signing. Canada (represented by Health Canada), BC (represented by the Ministry of Health), and BC First Nations (represented by the First Nations Interim Health Governance Committee Co-chairs – a sub-committee of the First Nations Health Council) reached agreement on a Basis for a Framework Agreement in March 2010.

The *British Columbia Tripartite First Nations Health Basis for a Framework Agreement on Health Governance* (the Basis for a Framework Agreement)⁶ is a



Basis for a Framework Agreement signing 2010: Grand Chief Doug Kelly, Chair FNHC; Honourable Leona Aglukkaq, Minister of Health; Andrew Hazlewood, ADM, Population and Public Health, BC Ministry of Health

non-binding political agreement between BC First Nations, Canada and the Province of BC signed on July 26, 2010⁷. This agreement was a precursor to a legally-binding *Tripartite Framework Agreement on BC First Nation Health Governance* that would follow. The Basis for a Framework Agreement: provided a roadmap for transferring Health Canada's BC operations to a future First Nations Health Authority (FNHA); outlined the agreement of the Parties to the basic elements of the new health governance structure and associated funding commitments; reaffirmed commitments to the Health Plans; provided clarification on the relationships between the Parties; and, established an agenda to better address the social determinants of health for First Nations in BC. The Agreement provided a basis for further dialogue with BC First Nations prior to reaching a legal agreement.

Importantly this Agreement protected FNIHB BC region funding from future cuts and re-confirmed the provincial government's funding commitment of 100 million dollars over 10 years. The Agreement established a payment schedule for the remaining 83.5 million dollars

2011 The BC Tripartite Framework Agreement on First Nations Health Governance

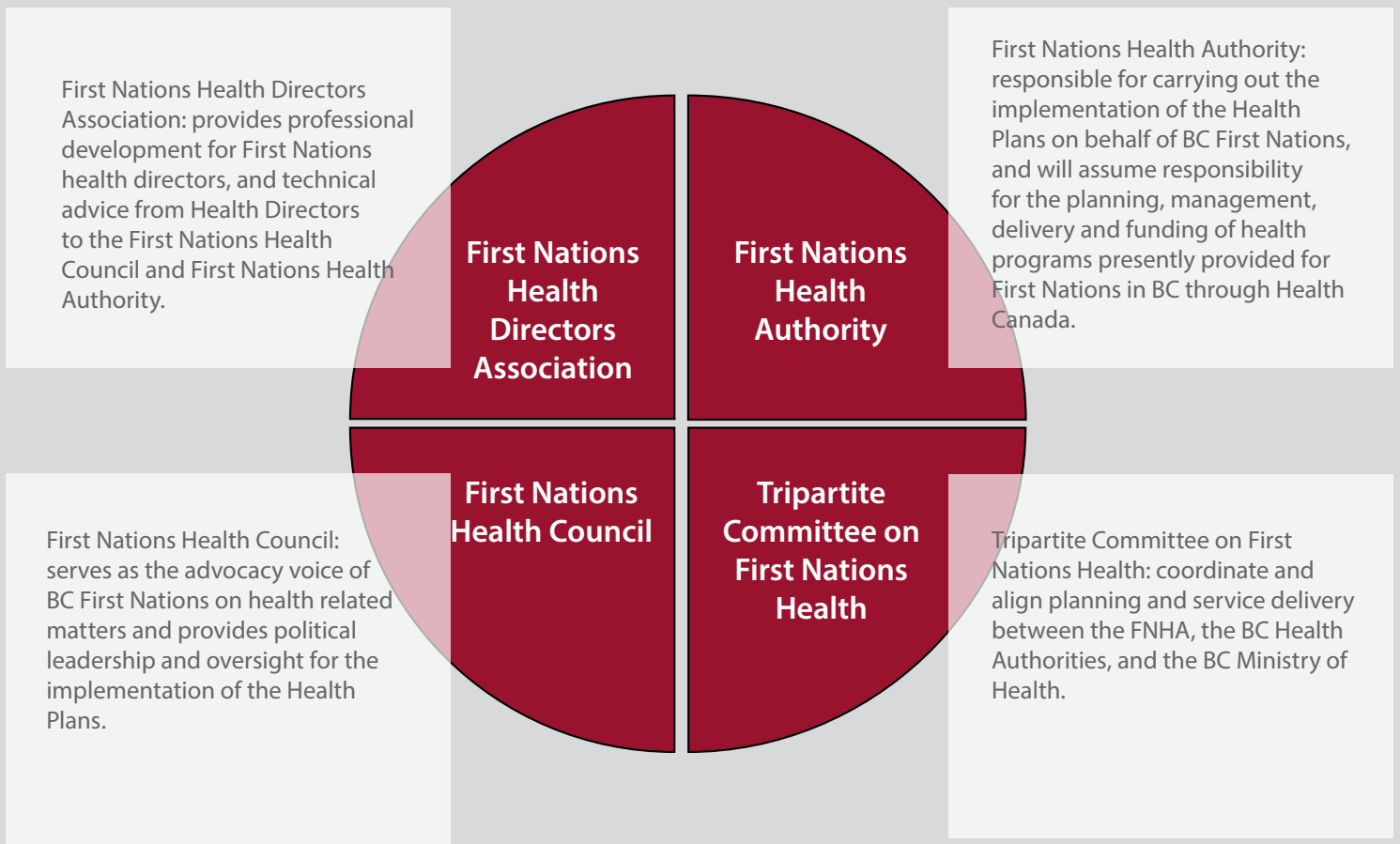
Progressing from the Basis Agreement to a legally-binding agreement was the next critical piece of work. Negotiation of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (hereafter referred to as the *Framework Agreement*) took less than a year, concluding in March 2011. The signing of the *Framework Agreement* is a key milestone in the implementation of the TFNHP.

This landmark legal agreement ensures BC First Nations will have a major role in the planning and management of health services by First Nations, for First Nations. It paves the way for the federal

government to transfer the planning, design, management and delivery of First Nations health programs to a new FNHA. It also established processes and timelines for the operations and functions of Health Canada's FNIHB-BC Region to be transferred to a new FNHA over a two-year period.

The agreement outlined that the federal transfer of programs and services would take place within two years, or later if necessary, to ensure a smooth transition. A transfer of federal health programs in 2013 would include the transfer of federal funding totaling approximately \$380 million per annum. This amount was based on federal expenditures for First Nations programs and services in British Columbia with an escalator to reflect expected population and cost increases.

The Framework Agreement served to further define the roles and responsibilities of the components that will play a role in the new First Nations health governance structure moving forward:





“THIS AGREEMENT IS A RESULT OF YEARS OF WORK BY BC FIRST NATIONS TO BRING FORWARD A FIRST NATION VISION OF HEALTH CARE. WE CANNOT BE PASSIVE OBSERVERS IN OUR OWN LIVES AND THE LIVES OF OUR FAMILIES AND COMMUNITIES – THIS AGREEMENT ENABLES FIRST NATIONS TO TAKE A STEP FORWARD IN TAKING BACK RESPONSIBILITY FOR OUR OWN LIVES AND FOR OUR OWN COMMUNITIES AND NATIONS. ASSEMBLY OF FIRST NATIONS”

- National Chief Shawn A-in-Chut Atleo, October 13, 2011, BC Tripartite Framework Agreement on First Nation Health Governance



Basis for a Framework Agreement signing ceremony 2010

Top left: Ian Potter, Chief Federal Negotiator, BC Tripartite and Anna Charlie (Sts'ailes); National Chief Shawn A-in-Chut Atleo, Honourable Leona Aglukkaq, Minister of Health with Anna Charlie and Virginia Peters (Sts'ailes); Wickaninnish Clifford Atleo Sr. leads a celebratory song.



Tripartite Framework Agreement Signing Ceremony October 11, 2011

From Left to right: Front – the Federal Health Minister Leona Aglukkaq, BC Minister of Health Mike De Jong, Grand Chief Doug Kelly, FNHA CEO Joe Gallagher, Standing – Graham Whitmarsh BC Deputy Minister of Health, National Chief A-in-Chut Shawn Atleo, FNHA Board President Pierre Leduc.



3) Structure: Establishing A New St



Establishing a “right fit” decision-making structure

Establishing a “right fit” decision-making structure among BC First Nations has been an ongoing and iterative process spanning the past five years. Establishing a structure that is accountable to BC First Nations, maintaining a clear separation of business from politics, and establishing appropriate venues and supports for dialogue among health technicians have been essential activities.

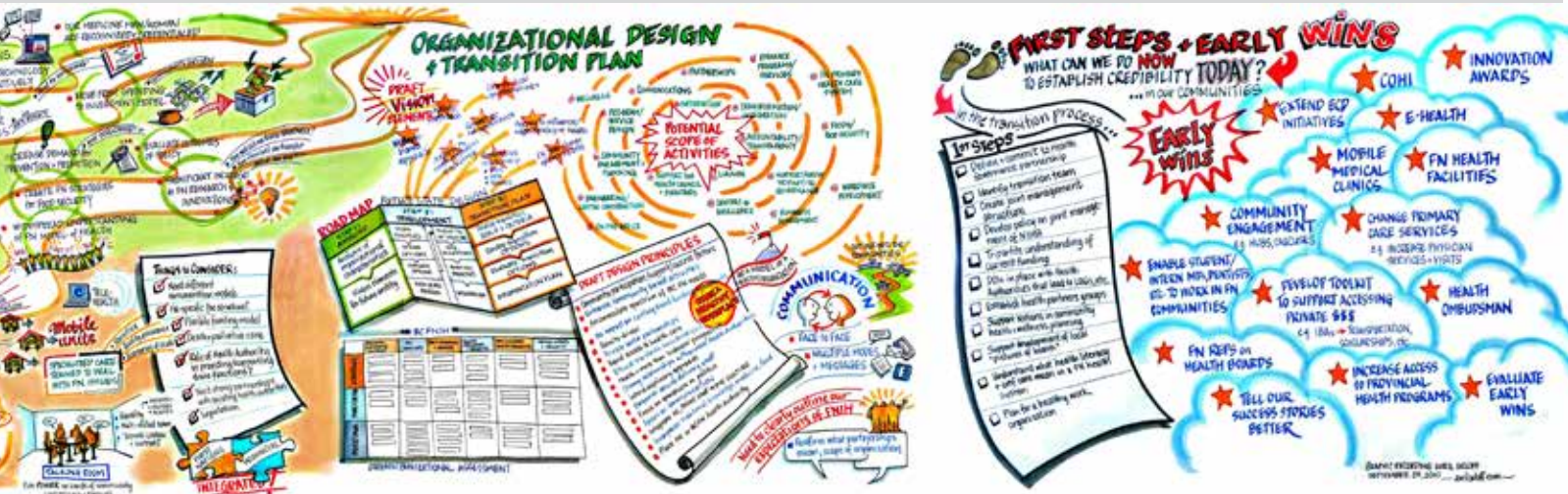
As such a structure had not been built in BC before this took some time to achieve. The process involved a back and forth between BC First Nations and proposed models put forth by staff and communicated through a series of regional caucus meetings using workbooks to describe recommendations and options. Through a process of deep consultation and ongoing involvement with First Nations a process was developed that met with support from the Chiefs and their advisors (Health Directors).

First Nations Health Council and the Venue for Political Discourse

The First Nations Health Council (FNHC) was established in 2007 to mirror the membership of the provincial First Nations Leadership Council (FNLC) and included three representatives of the UBCIC, three representatives of the FNS, and one representative of the BCAFN.

The FNHC was not developed as a legal entity, but as a political council to focus on implementation of the TCA: FNHP and the TFNHP at a political leadership level.

Structure For First Nations Health



First Nations Interim Health Governance Committee

The newly-formed FNHC quickly found that the agenda to politically implement the TFNHP was broad, and particularly that the commitments of the TFNHP focused on a new First Nations health governance structure required a separate focused dialogue. As a result, the FNHC formed a First Nations Interim Health Governance Committee (FNIHGC) in February 2008. Chief Wayne Christian (UBCIC), Grand Chief Edward John (FNS), and Grand Chief Doug Kelly (BCAFN) were appointed to serve as co-chairs of the Committee.

At the second Gathering Wisdom for a Shared Journey health conference¹, BC First Nations leadership supported the FNIHGC Co-Chairs to engage in a dialogue on health governance with all BC First Nation communities, and particularly with each Chief and senior health lead. This engagement work was supported unanimously through a formal resolution at the UBCIC (Res # 2008-25), the FNS (Res # 0608.22), and the BCAFN (Res # 29/2008). Specifically the resolutions mandated the delivery of a series of Regional Health Governance Caucus sessions to be held in the North, Interior, Fraser, Vancouver Coastal, and Vancouver Island regions of the province. These five regions aligned with the five provincial regional health authority boundaries and provided a framework to organize around.

The purpose of the initial Regional Caucus sessions was to:

- Determine how BC First Nations would work together;
- Seek BC First Nations support and establish effective communication;
- Select one person from each region as a member on the FNIHGC and establish role of regional and provincial caucus; and



Co-chairs of the Interim First Nations Health Governance Committee 2010: Kukpi7 Wayne Christian, Gwaans Bev Clifton Percival, and Tseem Grand Chief Doug Kelly (2009- Gitxsan Territory).

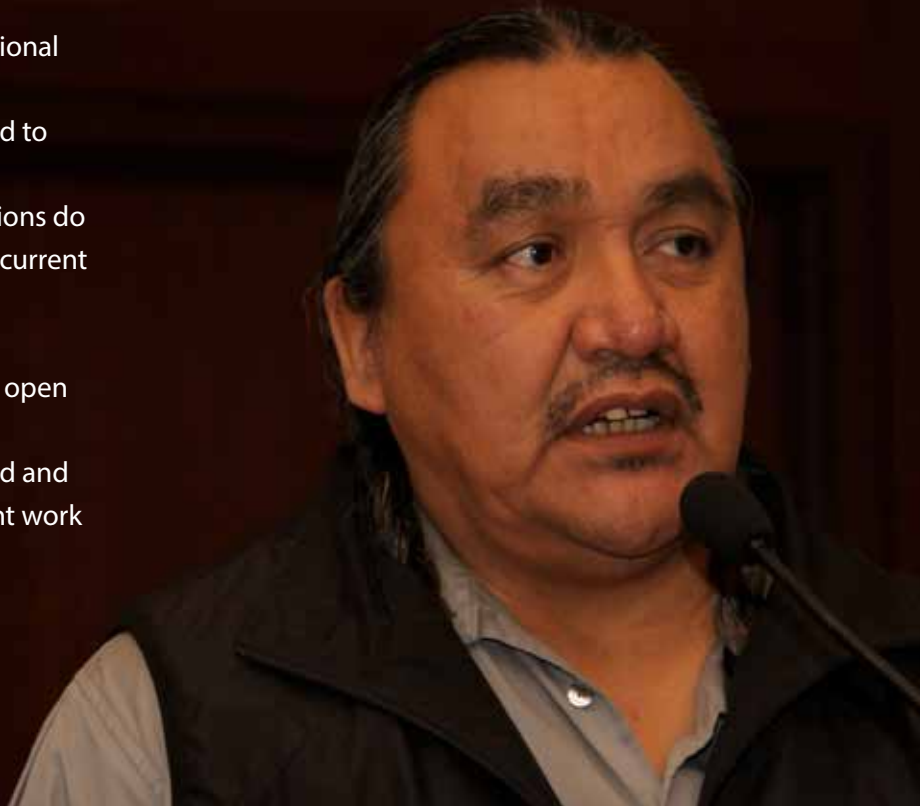
- Determine a BC First Nations political negotiations mandate for the FNIHGC.

Regional Caucuses were identified as an ideal forum to identify critical issues, gather information, and help prepare a mandate for this work. In support of this engagement, financial and human resources were provided by the FNHC for the FNIHGC and the Regional Caucuses to support the costs of continued dialogue and discussion for member communities. The FNIHGC and Caucuses also received support with communications, logistics and information sharing.

The initial Regional Caucus sessions held in 2008 led to numerous follow-up meetings in each region, supporting the principle that BC First Nations must have a voice in the development of a new health governance framework. These follow-up meetings resulted in the establishment of a 22

Themes emerging from initial Regional Governance Sessions included:

- BC First Nations are committed to working together
- Culture is important, First Nations do not want to simply adopt the current FNIH system.
- Communication is critical, the negotiations process must be open and transparent.
- The regions must be resourced and supported to do the important work ahead.



Chief Mike Archie, Canim Lake Band at a 2008 Regional Health Caucus Session

member regionally appointed First Nations Interim Health Governance Committee and provided the FNIHGC Co-Chairs with information to develop a negotiations mandate and to enter into further talks with BC and Canada.

Restructuring the First Nations Health Council

As the five Regional Caucuses became more firmly established through the health governance process, leadership began to re-examine the membership and structure of the FNHC. As strong ownership and commitment to the grassroots appointment process was considered paramount, a debate was opened at the three political assemblies on the role and representation of the FNHC.

In early 2010 the UBCIC, FNS, and BCAFN passed resolutions calling for the seven-member, politically appointed FNHC to transition to one comprised of regional representatives, mirroring the structure of the FNIHGC. The resolutions required that each region appoint three representatives to a new 15-member FNHC. The new FNHC structure had a two-year mandate and was designed to be inclusive of the full scope of work to implement the Health Plans. Appointments to the newly-structured FNHC occurred between March and May of 2010 through regionally determined processes.

Evolving a First Nations Health Authority and Establishing Capacity to Implement the Health Plans

Establishing a First Nations Health Society

In 2007-2008, technical support to implement the Health Plans was comprised of a few policy analysts working in the physical offices of the UBCIC, BCAFN and FNS, with corporate functions and legal liabilities assumed by the FNS². From the outset, the small team was challenged to meet the quickly evolving needs of the health reform process.

In 2008, recognizing that the scale of work had outgrown this structure, the FNHC directed a sub-committee to explore options for creating an administrative body to assume these responsibilities. These investigations resulted in a proposal to establish a non-profit society to take on the legal and administrative functions for Health Plan implementation. The FNHC approved the recommendation and transitional planning was initiated in the fall of 2008 to form the First Nations Health Society (FNHS).

As part of this work, the FNHC considered structural options for the creation of the FNHS, contemplating issues such as:

- Reporting and Accountability
- Political direction from First Nations leadership
- Strategic direction and advancing the TFNHP
- The need to determine clearly the roles and responsibilities of the new Society

The FNHC determined that in order to effectively work with and meet the needs and expectations of First Nations leadership, while still having an ap-

propriate separation of business from political decisions, the new Society would need a dedicated Board of Directors at arms-length from the political FNHC. These Directors would need to be apolitical since they would have authority over spending decisions affecting First Nations communities. It was agreed that FNHC would retain the responsibility of direct reporting to First Nations on the work of the new Society and that this would be a key function of the FNHC as members of the FNHS.

During subsequent meetings, the FNHC set criteria for a recruitment process. They agreed that Direc-

The First Nations Health Society was officially registered³ on March 6, 2009 and started as a new legal entity on April 1, 2009. The FNHS Constitution outlined that the FNHS would:

- Operate as the administrative and funding arm for the FNHC, which has been mandated to advance First Nations health issues in BC;
- Provide health services to First Nations;
- Receive and administer funds and other assets from the Government of Canada, the Province of BC and from any other source, and to apply such funds and assets for the attainment of the purposes of the Society; and,
- Do all things that are incidental and conducive to the attainment of the above purposes.



First Nations Health Council members are also the members of the First Nations Health Authority, this relationship ensures direct accountability to the Nations and regions.

tors of the FNHS should have expertise in governance, legal, human resources and financial areas, and not have any current tie to potential recipients of funding from the FNHS. In order to maintain direct accountability to community, it was agreed that the seven members of the FNHC would become the members of the FNHS – responsible for providing governance-level oversight and guidance for the work of the FNHS.

Initial appointees to the FNHS Board of Directors included: Carol-Anne Hilton, Matt Pasco, Ruth Williams, Pierre Leduc, John Scherebnyj, Madeleine Dion Stout, and Marilyn Rook. The relationship between the FNHS (operations) and the FNHC (political advocacy) was divided by a legal line of liability. It was agreed that the FNHS would provide administrative support to the FNHC, and would take its strategic direction from the FNHC. The

Board of Directors was to ensure the Society meets its corporate and legal obligations in support of the implementation of the TFNHP.

At its inception, the FNHS was bound by existing legal agreements with federal and provincial funders that were negotiated prior to its formation, and prior to the establishment of the Health Plans. Some of these agreements placed constraints on the Society in terms of how funds were applied and what activities could be performed. A number of programs that did not ‘fit’ the FNHS’s intended role of supporting the implementation of the TFNHP. The FNHS made a decision to separate itself of most of the programs and to refocus on the work under the TFNHP. The FNHS spent a great deal of time and effort working with funders to ensure that funding agreements supported the strategic directions of First Nation communities and not just government priorities.



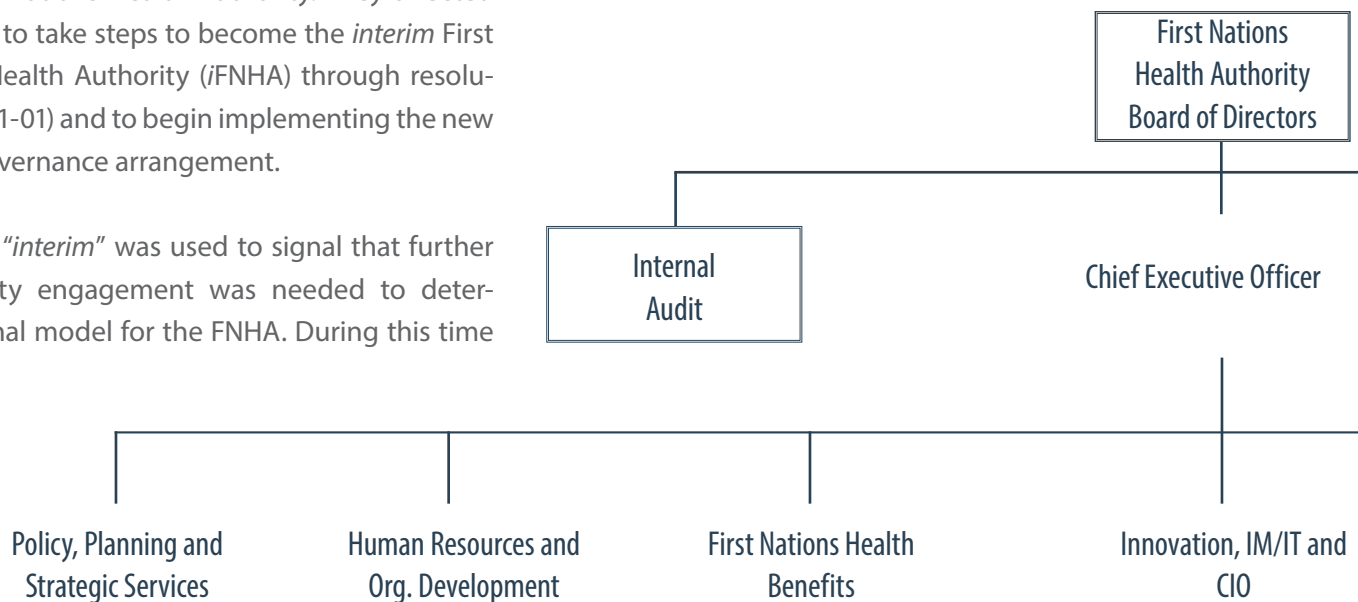
Establishing senior First Nations capacity to implement the Health Plans: Dr. Georgia Kyba, Traditional Medicine Advisor, Mr. Joe Gallagher, Chief Executive Officer and Dr. Evan Adams, Deputy Provincial Health Officer for BC.

A New First Nations Health Authority

At Gathering Wisdom for a Shared Journey IV⁴, First Nations Chiefs directed the FNHC to develop models and options for the creation of a permanent First Nations Health Authority. They directed the FNHS to take steps to become the *interim* First Nations Health Authority (*iFNHA*) through resolution (#2011-01) and to begin implementing the new health governance arrangement.

The term “*interim*” was used to signal that further community engagement was needed to determine a final model for the FNHA. During this time

there would be further work to develop the governance and structure of a permanent Health Authority through First Nations political discussion and approval.



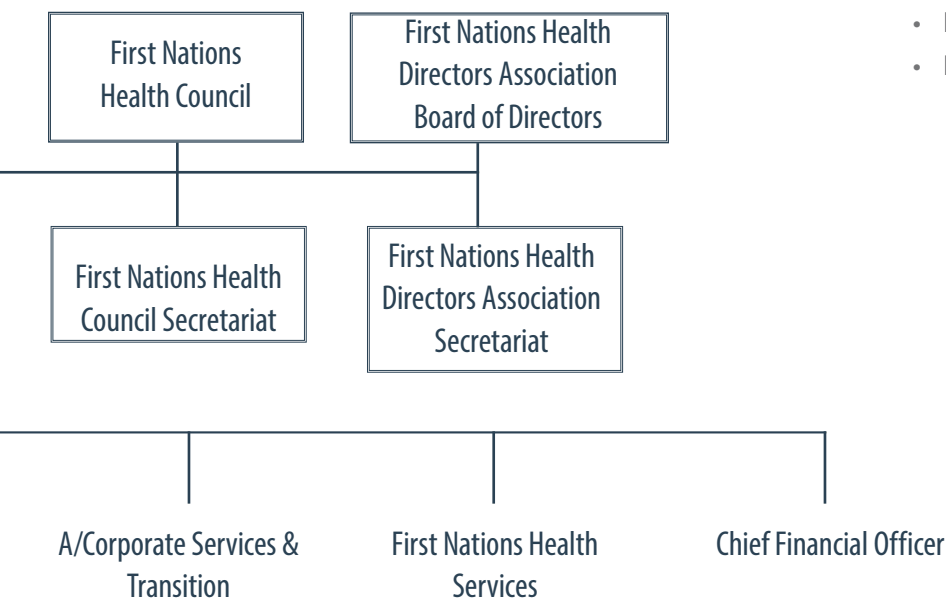
Over the next year, First Nations leadership reviewed what the final governance structure the FNHA could look like⁵. BC First Nations leadership supported a holistic model for the organization, which would blend the best of non-profit, corporate and legislative tools. All subsidiary corporate or non-profit entities would be accountable to the FNHA Board of Directors. BC First Nations Chiefs also agreed-upon a new Board of Directors structure, expanding to a 9-member Board with four at-large appointments and five appointments drawn from the five regions of BC. Chiefs also re-stated that the FNHA must maintain a separation of political/governance from operational roles. These decisions were formalized during Gathering Wisdom for a Shared Journey V forum in May of 2012, where First Nations also voted to transition the iFNHA to a permanent FNHA.

On August 21, 2012 provincial naming by-laws were changed to remove 'interim' and officially recognize the title of the FNHA. The change was a legal formality and a key milestone in the creation of the first province-wide FNHA of its kind in the country.

Provision of the Secretariats

Throughout the process First Nations have clearly stated that available resources must be spent wisely, and that administrative costs are to be streamlined as much as possible. From the outset, it was agreed that the FNHS, and now the FNHA, would serve as the central administrative body, and provide administrative support services in support of the mandates and activities of the FNHC and the First Nations Health Directors Association. Thus, the FNHA resources a support team dedicated to the work of the FNHC, and another for the FNHDA, referred to as the FNHC Secretariat and the FNHDA Secretariat. These teams are each led by an Executive Director, supported by a small number of additional staff, that provides strategic advice, technical analysis, and coordination in support of the FNHC and FNHDA functions. The FNHC and FNHDA Secretariats are supported by further corporate services of the FNHA, such as:

- Finance
- Human resources
- Information & records management
- Technology
- Community engagement
- Communications
- Administrative and coordination services
- Office accommodations
- Legal
- Policy





Founding members of the First Nations Health Directors Association. From left to right: Back – Allison Twiss, Georgia Cook, Jeanine Lynxleg; Centre – Hertha Holland, Jacki McPherson, Patrick Lulua; Front – Judith Gohn, Virginia Peters, D. Laurette Bloomquist and Nora Martin. Missing are Jim Adams and Aileen Prince.

Care for the Caregiver: The First Nations Health Directors Association

The creation of a First Nations Health Directors Association (FNHDA) was one of the four governance components described in the TFNHP:

An Association of Health Directors and other health professionals will create and implement a comprehensive capacity development plan for the management and delivery of community-based services and support First Nations and their mandated health organizations in training, program development and knowledge transfer⁶.

A subcommittee of seasoned Health Directors led the developmental work of the Association, culminating in a vote during the annual Gathering Wisdom Forum in 2009. The Health Directors in attendance voted overwhelming in support of the model provided.

The FNHDA was registered in April 2010⁸ with resources and staff support provided by the FNHA. The structure of the FNHDA mirrors that of the FNHC – a 15-member Board of Directors comprised of appointed representation from each of the five



“WE ARE VERY EXCITED ABOUT THE FORMATION OF THE FIRST NATIONS HEALTH DIRECTORS ASSOCIATION. THE FIRST NATIONS HEALTH DIRECTORS ASSOCIATION REPRESENTS A COLLECTIVE OF THE BEST FIRST NATIONS HEALTH TECHNICAL ADVISORS IN THE PROVINCE. THIS COLLECTIVE OF EXPERIENCE AND KNOWLEDGE CAN PROVIDE ANALYSIS, ADVICE AND RECOMMENDATIONS RELATED TO HEALTH PLANNING, SERVICE DELIVERY, MEASURABLE OUTCOMES AND MUCH MORE.”

- Kim Brooks, Health Director for the Squamish Nation and FNHDA Executive⁷

regions; North (3 seats), Interior (3 seats), Vancouver Island (3 seats), Vancouver Coastal (3 seats), and Fraser (3 seats).

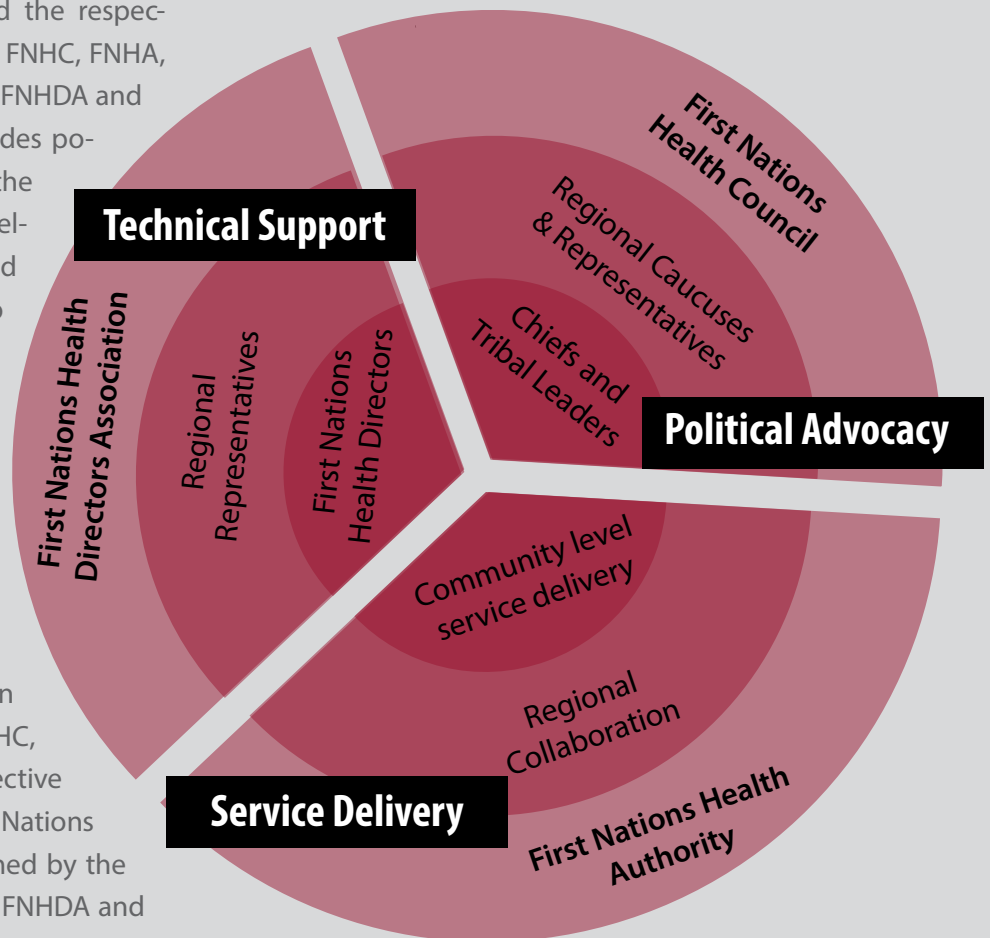
The FNHDA supports education, knowledge transfer, professional development and best practices for health directors and managers. As it is composed of the health service experts in First Nations communities, the FNHDA also has an important role in providing technical advice to the FNHC and the FNHA on research, policy, program planning and design, and the implementation of the Health Plans.



FNHDA President Jackie McPherson and Executive Director, Christine Stahler. December 2012.

Pulling together: Consensus Leadership

First Nations have clearly endorsed the respective roles and responsibilities of the FNHC, FNHA, and FNHDA. The roles of the FNHC, FNHDA and FNHA are different: the FNHC provides political leadership and oversight; the FNHDA provides professional development for health directions and managers and provides advice into health policy and program matters; and, the FNHA designs and delivers health and wellness programs and services, provides secretariat support to the FNHDA and FNHC, and holds legal and financial accountabilities. These roles are complementary and continue to evolve, and require collaboration and cooperation amongst the FNHC, FNHDA and FNHA to ensure the effective and efficient functioning of the First Nations health governance structure. Informed by the work amongst the FNLC, the FNHC, FNHDA and FNHA recognize that the strength of our work arises from a collective voice.



Shared values of Consensus Leadership

Respect; Discipline; Relationships;
Culture; Excellence; and, Fairness.



Relationship Agreement signing ceremony November 2012. L-R: Warner Adam, Deputy Chair, FNHC, Jeanine Lynxleg, Vice-President, FNHDA, Joe Gallagher, Chief Executive Officer, FNHA, Pierre Leduc, Vice-Chair, FNHA, Jackie MacPherson, President, FNHDA, Grand Chief Doug Kelly, Chair, FNHC.

In August 2011, the FNHC, FNHDA and FNHA held a joint planning session. From that session emerged a commitment to a shared vision of “Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities.” Also emerging from that session was a set of shared values: Respect; Discipline; Relationships; Culture; Excellence; and, Fairness. To implement this vision and values in practice, the FNHC, FNHDA and FNHA committed to an ongoing working partnership through a Collaboration Committee composed of the executive and senior staff leadership of each group. The purpose of the Collaboration Committee is to support *consensus*

leadership amongst the FNHC, FNHA, and FNHDA – a place to coordinate, share information, strategize, and develop common understandings. These outcomes arising from the August 2011 planning session were outlined in an FNHC-FNHA-FNHDA Relationship Agreement signed in November 2012. This Relationship Agreement outlines the sound partnership sought by the Parties – a partnership based on shared values and understanding of collective and respective roles, responsibilities, and accountabilities.



4) Partnerships: Building Block

“HOW WE ENVISIONED OUR PARTNERSHIP IN THE EARLY DAYS IS A LOT DIFFERENT THAN HOW WE ARE LOOKING AT IT TODAY. THAT IS WHAT THE HEALTH PARTNERSHIP ACCORD IS ABOUT. IT’S ABOUT THAT FACT THAT OUR PARTNERSHIP IS GROWING AND EVOLVING, AND ITS GROWING THE WAY THAT IT NEEDS TO, BASED ON HOW THE THREE PARTIES RECOGNIZE WHERE WE WANT TO BE COLLECTIVELY.”

- Joe Gallagher, Chief Executive Officer, FNHA

Since the very beginning of the process, there has been a mutual understanding between BC First Nations and government partners about the need for partnerships and collaboration to improve health and well-being of BC First Nations.

“The Government of British Columbia, First Nations and the Government of Canada agree that new approaches for addressing the rights and title interests of First Nations are required if First Nations are to be full partners in the success and opportunity of the province.” (Transformative Change Accord, 2005)

“This multi-jurisdictional health care system for First Nations at times creates gaps, discontinuities and inadequacies in service. Programs to address health problems are often developed independently by one or more of the provincial, federal or First Nations partners, so that well intentioned initiatives may create overlaps or duplication.” (The Transformative Change Accord: First Nations Health Plan, 2006)

Reciprocal Accountability

The concept of Reciprocal Accountability is a key element of the new health partnership. Historically, accountability has been a one way relationship from First Nations to governments for funds received. Under the new health governance arrangement, accountability is much broader and not just about money. It is about working together and each Party being responsible for the effective operation of their part of the health system recognizing that the space occupied by each is interdependent yet interconnected.

Reciprocal accountability means shared responsibility – amongst First Nations (at community, regional and provincial levels), the Federal Government, and the Provincial Government (including Health Authorities) – to achieve common goals. In the 2005 BC Blueprint, Reciprocal Accountability was defined as:

s Of Change

Through the Framework Agreement, the partners once again confirmed that it was important to “establish a new and enduring relationship, based on respect, Reciprocal Accountability, collaboration and innovation that is conducive to the pursuit of improved health and wellness for BC First Nations.” To ensure the ongoing evolution and growth of their partnership, BC First Nations and federal and provincial governments have established a number of mechanisms and agreements.

“A process through which all parties to a plan, action, agreement, etc. take mutual responsibility for their conduct, one to another. Accountability must be a reciprocal process. For every increment of performance I demand from you, I have an equal responsibility to provide you with the capacity to meet that expectation. Likewise, for every investment you make in my skill and knowledge, I have a reciprocal responsibility to demonstrate some new increment in performance.” FNLC Health Blueprint (2005)

key player Dr. Evan Adams

Deputy Provincial Health Officer



In 2008, Dr. Evan Adams was appointed Aboriginal Physician Advisor to provide input and direction into health services provided by the province of BC to First Nations and to monitor, track and report on health progress of First Nations communities.

In 2012, and enabled by the Tripartite Framework Agreement signed in 2011, Dr. Adams as-

sumed the role of Deputy Provincial Health Officer. As Deputy PHO Dr. Adams works alongside Provincial Health Officer Dr. Perry Kendall and Deputy PHO Dr. Eric Young by providing independent direction on First Nations and Aboriginal health issues to the Ministry of Health, reporting to citizens on health issues affecting the general population, and setting out a path for the improvement of First Nations and Aboriginal health and wellness. Dr. Adams' new role reflects a strengthening of the partnership between the Province of B.C. and B.C. First Nations.

Dr. Adams is a Coast Salish physician and actor from the Sliammon First Nation located near Powell River. Previously he served as Aboriginal health physician advisor to government and the First Nations Health Council, contributing to positive developments in health for all citizens in B.C. while making substantial improvements in service delivery to First Nations in the province.

As the chief resident during his family practice residency in the Aboriginal Family Practice Program at St. Paul's Hospital in Vancouver, he won the provincial Family Medicine Resident Leadership Award from the College of Family Physicians of Canada (CFPC) and the Murray Stalker Award from the CFPC Research and Education Foundation.

"DR. ADAMS HAS ALREADY MADE A STRONG CONTRIBUTION TO ABORIGINAL HEALTH HERE IN B.C., AND I KNOW THAT HE WILL CONTINUE TO DO SO AS DEPUTY PHO. HIS APPOINTMENT WILL SIGNIFICANTLY STRENGTHEN THE CAPACITY OF THE OFFICE AND I LOOK FORWARD TO WORKING WITH HIM IN THIS ENHANCED ROLE".

- Dr. Perry Kendall, Provincial Health Officer

Reciprocal Accountability forms a key piece in relationships with partners. It allows First Nations to hold government and health authorities responsible for improving health outcomes and performance. It replaces one-sided accountability, which saw First Nations doing onerous reporting on program funds they received without the opportunity to hold funders and others responsible for their obligations. Reciprocal Accountability represents a very different way of doing business and a new best practice for working collaboratively with BC First Nations.

Reciprocal Accountability was an essential part to making the process a success. All partners had to answer to each other and communities for their decisions. It went hand in hand with partners being 'tough on the issues but easy on each other', finding effective solutions to health service issues by coming to the table as equals for all discussions and decisions.

To bring the concept of Reciprocal Accountability into focus, an important action item in the Health Plans was the development of a Reciprocal Accountability Framework (RAF). This framework laid out the responsibilities of the Province, Canada, Regional Health Authorities, the First Nations health governance structure, and First Nations communities toward improving the health of First Nations in BC. In 2008, a senior management team, composed of representatives from the Province, Health Canada and the FNHC, met with executives of each Regional Health Authority. The purpose of these meetings was to begin regionally-focused discussions on how each Regional Health Authority is accountable to the local First Nations popula-

tions they serve, and how to better reflect this in the planning, funding and decision-making processes. Reciprocal Accountability is also addressed in the Framework Agreement:

“WHEN YOU CALL SOMEONE TO TALK, THEY CAN'T SAY 'THAT'S NOT MY JOB' ANYMORE, THERE IS MORE OF A REALIZATION THAT WE HAVE TO SHARE THIS JOB OF LOOKING AFTER FIRST NATIONS HEALTH WHETHER ON RESERVE, OR OFF-RESERVE”

- Dr. Shannon Tania Waters, Director of Surveillance, First Nations and Inuit Health Branch, Health Canada.

The actions of the Parties under this Agreement will be based on reciprocal accountability, which means that the Parties will work together in a collaborative manner to achieve the objectives set out in Recital I and section 2.1, respecting both the letter and spirit of the Agreement, and in accordance with their respective obligations hereunder. In the event that implementation challenges are identified which do not constitute default under the terms of the Agreement but which nevertheless compromise its effectiveness or sustainability, the Parties will meet in accordance with processes established hereunder and with appropriate officials, or otherwise as agreed, and strive to develop responses, measures or strategies to meet the challenges identified, where possible. The Parties will also seek to apply the concept of reciprocal accountability at the regional and local level.

Principals Table

To support the functioning and implementation of the Framework Agreement, BC, Canada and First Nations have agreed to a series of high-level political meetings. The Chair of the FNHC and the federal and provincial Ministers of Health will meet on a biennial basis to provide political oversight to the ongoing health partnership and the implementation



Provincial executives and regional health authority CEO's - 2011 Tripartite Committee on First Nations Health Meeting

of the Health Plans and agreements. The maintenance of the relationship at the highest level is key to ensuring the ongoing commitment of the parties to the goals and objectives of the Health Plans.

Tripartite Committee on First Nations Health

The establishment of the Tripartite Committee on First Nations Health (TCFNH) was mandated through the bi-lateral TCA: FNHP. The Committee was originally known as the Provincial Advisory Committee on First Nations Health. At the recommendation of the Committee, the term "Advisory" was dropped in 2009 to better reflect the decision-making nature of the table. Finally, in 2010 the "Provincial" was changed to "Tripartite" to better signal the full inclusion of the federal government at this table.

The TCFNH is an important forum for political and executive level relationships to be fostered and maintained between First Nations leaders and government partners.

The TCFNH table has provided an effective barometer to measure the progress of Health Plan implementation. As the tripartite partnership has grown, so too has the efficacy of the table. Trust and understanding were largely absent in the early days of Health Plan implementation. With each progressive agreement, the relationship between the partners was clarified. During the first few meetings, regional health authorities largely participated in the conversation by reporting on what each was already doing in the area of Aboriginal Health. More recent meetings have focused on innovation and partnership and what can be achieved by working together.

TCFNH MEMBERSHIP

Tripartite Committee on First Nations Health table membership includes:

- the President/ Chief Executive Officers of each of the BC Health Authorities;
- the Provincial Health Officer under the BC Public Health Act and the Aboriginal Health Physician Advisor;
- the Chairperson and Deputy Chairperson of the FNHC;
- one representative from each of the 5 First Nations regional tables;
- the Chief Executive Officer of the FNHA;
- the President of the FNHDA;
- the appropriate Associate Deputy Minister and Assistant Deputy Minister of the BC Ministry of Health; and, any other non-voting, observer or full members as agreed to by the Tripartite Committee.

“NEGOTIATING AND SIGNING THE FRAMEWORK WAS A BIG TASK BUT NOW WE HAVE A BIGGER TASK IN FRONT OF US. WE ARE TRYING TO ACHIEVE REMODELING OR NEW WAYS OF WORKING WITH OUR PARTNERS, PROVINCES, TERRITORIES AND FIRST NATIONS TO IMPROVE THE QUALITY OF SERVICES. WE ARE DEFINING NEW WAYS OF WORKING TOGETHER.”

- First Nations & Inuit Health Branch Assistant Deputy Minister Michel Roy. TCFNH meeting, February 20, 2012

TCFNH MANDATE

Meeting bi-annually, the TCFNH ensures that the commitments in the health plan are being honoured; more specifically, the TCFNH:

- Coordinates and aligns planning, programming, and service delivery between the FNHA, BC Health Authorities and the BC Ministry of Health, including the review of their respective FNHA *Multi-year Health Plan* and BC Regional Health Authorities' Aboriginal Health Plans;
- Facilitates discussions and coordinates planning and programming among BC First Nations, the Province of BC and Canada on all matters relating to First Nations health and wellness;
- Provides a forum for discussion on the progress and implementation of the Framework Agreement and other health arrangements including the Transformative Change Accord: First Nations Health Plan (2006), the First Nations Health Plan MOU (2006), the Tripartite First Nations Health Plan (2007) and the Health Partnership Accord (2012 – see section below for more information);
- Prepares and makes public an annual progress report for the Minister of Health (BC), the Minister of Health (Canada) and the FNHC on the progress of the integration and the improvement of health services for First Nations in BC; and
- Undertakes such other functions as the Tripartite Committee members may from time to time agree, and which are consistent with the purposes and intent of this Agreement and its terms of reference.

Tripartite Health Actions Strategy Councils

The Transformative Change Accord: First Nations Health Plan (TCA: FNHP, 2006) initially identified 29 'Health Action' items, which have evolved over the years as further engagement with First Nations takes place, and lessons from implementation of the health actions are gained. The tripartite partners have agreed to a common goal for this work:

Proactive health system transformation for developed capacity, relationships that work, and innovative community-driven processes that are responsive to increased First Nations authority over health.

Senior executives of the tripartite partners called the *Tripartite Management Team* (TMT) agreed to the formation of strategic 'tables.' Called Tripartite Strategy Councils, these tables consist of senior executives from the partner governments who are currently responsible for decision-making in these service areas. The TMT also agreed that FNHA senior personnel would sit with the partners to develop initial strategic approaches to create the space for First Nations to engage directly on these action items at the planning and implementation levels.

Three **key principles** underpin all 'Health Actions' work:

- **Tripartite Collaboration:** The Tripartite partners will be at the table together to discuss transformation of health services that will benefit the health of First Nations communities through a new collaborative way of working. This requires that the 'decision-makers' on all sides are at the table to inform, plan and make decisions about system change that is needed. They will also monitor the changes as they occur;
- **First Nations decision-making:** First Nations must be at the table where any decisions are made that affect them and have an increased role in decision-making about their services. This reflects increased First Nation decision-making in health at all levels from strategy and planning to implementation and service delivery.
- **Systems Transformation:** services need to continue to change, adapt and improve so that they are more appropriate, accessible and effective for First Nations.



Tripartite strategy council leads: L-R: Jane Mather; Tara Nault ; Joan Geber; Dr Shannon Waters; Kelly McQuillen; Ann Marr; and Christa Williams.



THE HEALTH PARTNERSHIP ACCORD ADVANCES OUR COMMITMENT TO FIRST NATIONS HEALTH CARE BY COLLABORATING WITH B.C. FIRST NATIONS ON THE HEALTH OF THEIR PEOPLE, WE ARE PROUD TO FURTHER STRENGTHEN OUR TRIPARTITE RELATIONSHIP WITH THE FEDERAL GOVERNMENT, THE FIRST NATIONS HEALTH COUNCIL, AND THE FIRST NATIONS HEALTH AUTHORITY TO BETTER MEET THE NEEDS OF FIRST NATIONS.

- Margaret MacDiarmid, Minister of Health, British Columbia

The Tripartite partners signed the Health Partnership Accord on December 17, 2012, fulfilling one of the commitments in the Framework Agreement. Seen here are – from left to right: Seated; Grand Chief Doug Kelly (FNHC Chair), Leona Aglukkaq (Federal Health Minister, Canada), Margaret MacDiarmid (Provincial Health Minister, BC), Lydia Hwitsum (FNHA Board Chair); standing- Warner Adam (FNHC Deputy Chair), Glenda Yates (Deputy Minister of Health, Canada), Graham Whitmarsh (Deputy Minister of Health, BC), and FNHA CEO Joe Gallagher.

Health Partnership Accord

On December 17, 2012 Federal Health Minister Leona Aglukkaq, British Columbia Health Minister Margaret MacDiarmid, and Grand Chief Doug Kelly, Chair of the B.C. First Nations Health Council signed a Health Partnership Accord today re-affirming their long-term commitment and shared vision for a better, more responsive and integrated health system for First Nations in British Columbia.

British Columbia Health Minister Margaret MacDiarmid and FNHA Chief Executive Officer Joe Gallagher, Health Partnership Accord Signing Ceremony December 2012.

The Health Partnership Accord is a commitment of the British Columbia Tripartite Framework Agreement on First Nation Health Governance (Framework Agreement) signed by the parties in October 2011. The Framework Agreement is guiding the transfer of responsibility for design and delivery of all federally funded health programs and services for British Columbia First Nations, currently administered by Health Canada, to the First Nations Health Authority.

PARTNERSHIP PRINCIPLES

- **Lead with culture:** Understand your Partners and where they come from.
- **Honour those who paved the way:** Pay respect to, and honour the wisdom of, those that brought us to where we are today.
- **Maintain unity and discipline:** Work for the common good of all; do not criticize one another; recognize that we all have a role to play.
- **Create strong relationships:** be tough on the issues and easy on each other: Seek opportunity to create understanding and support one another's dignity.
- **Engage at the appropriate level:** Partners must have authority, skills, and knowledge to fully contribute.
- **Respect each other's process:** Seek understanding of, acknowledge and respect the validity of one another's ways of working and decision-making processes, and provide assistance to one another in navigating these processes.

The Health Partnership Accord describes the broad and enduring relationship amongst the Partners. It uses the theme of a "journey" and relies on the wisdom, vision, and guidance provided by First Nations through the over 150 Regional and Sub-Regional Caucus meetings to date to describe the Partners' ongoing commitment to their health partnership.

The Accord:

- Reflects upon successes achieved to date in the partnership, how the partners have evolved over time, and acknowledges that the partnership requires each Party to be accommodating and make adjustments along the way
- Outlines the commitment to the new health governance structure that brings decision-making closer to home and recognizes First Nations decision-making processes and institutions
- Discusses the commitment to better coordination, collaboration, integration, and equitable access to services
- Confirms the broad wellness and social determinants approach
- Envisions possibilities, including for a wellness system, in health planning, for health services, in e-health, economic innovation, and cultural competency
- Reflects upon the need for each partner to mobilize their respective contributions, authorities, assets, and innovations towards shared commitments
- Outlines a definition of reciprocal accountability, and a commitment to resolve conflict in a good way
- Is an "evergreen" document, that will be updated as needed to capture the evolving nature of the partnership

THIS ACCORD IS SIGNIFICANT FOR A NUMBER OF REASONS. IT COMMITS EACH OF THE PARTNERS TO CONTINUE TO WORK TOGETHER IN A GOOD WAY. WE WON'T NEED TO REFER TO THIS DOCUMENT WHEN TIMES ARE EASY, ONLY WHEN WE ARE IN TIMES OF DIFFICULTY. WE SHOULD ALWAYS REMIND OURSELVES AND OUR PARTNERS WHY WE HAVE COME TOGETHER – TO MAKE THE LIVES OF OUR PEOPLE AND THE CONDITIONS OF OUR COMMUNITIES BETTER.

- Grand Chief Doug Kelly, Chair, First Nations Health Council



WHEN I THINK OF HEALTH, ONE THING THAT COMES TO MIND IS ACCESS TO OUR TRADITIONAL FOODS. THE SIGNING OF THIS PARTNERSHIP ACCORD TODAY REMINDS ME OF GOING FISHING.

I REMEMBER WHEN OUR FAMILY WOULD GO FISHING IN ONE OF OUR OLD VILLAGES, SEVERAL FAMILIES WOULD COME TOGETHER UNDER SEVERAL CHIEFS AND LEADERS.

WE HAD MANY TASKS TO ACCOMPLISH AND MUCH WORK TO BE DONE. AS TEAMS SET OUT TO WORK, WITHOUT CELL PHONES OR MODERN TOOLS AND TECHNOLOGY, WE LEARNED TO TRUST AND RELY ON EACH OTHER.

THE BASICS OF SURVIVAL LIKE FOOD AND SAFETY WERE PUT INTO EACH OF OUR HANDS, I DID NOT FEAR FOR NOT HAVING ANY OF THESE THINGS, I HAD TRUST IN THE COMMITMENTS WE HAD AND UNDERSTOOD THE SPIRIT OF HOW WE SUPPORTED EACH OTHER AND ALL WORKED TOGETHER.

MANY FAMILIES AND LEADERS FROM SEPARATE HOUSES COME TOGETHER, WE SHARE IN THE EFFORT AND RESPONSIBILITY, AND WE ARE ACCOUNTABLE AND SUPPORTIVE OF EACH OTHER.

THESE SYSTEMS AND WAYS OF WORKING TOGETHER WERE SEAMLESS, DEVELOPED OVER GENERATIONS.

I SEE THIS IN THE ACCORD THAT WAS SIGNED TODAY, IT WILL HELP US WORK TOGETHER FOR YEARS TO COME REGARDLESS OF WHO IS SITTING AT THIS TABLE. THIS ACCORD ESTABLISHES THOSE SYSTEMS AND WAYS OF WORKING TOGETHER FOR OUR FUTURE GENERATIONS.

- Nick Chowdhury, First Nations Health Council

Regional Partnership Accords

Provincial level agreements previously discussed have illustrated high-level political commitment to the process. In addition, First Nations within the regions and each of the Regional Health Authorities have been developing their own processes to develop regional partnerships. The enabling of regional partnerships was a commitment both in the Framework Agreement and the British Columbia First Nations *Perspectives on a New Health Governance Arrangement Consensus Paper*¹ and progress is reported regularly through the TCFNH.

Since 2008, First Nations Regional Caucuses have provided opportunity for Community-Driven, Nation-Based decision-making. Regional Caucuses provide an important venue for First Nations share information, perspectives, and set direction on regional health matters. Regional Caucus representatives also appoint representatives to the FNHC through their own regionally-determined processes. These Caucuses act as mechanisms to carry information from BC First Nations communities to the provincial level and vice versa. They have formed the backbone of the movement to reform health governance for BC at the local and regional level.

First Nations through Regional Caucuses and Regional Health Authorities have made significant strides in solidifying regional partnerships this past year, building on the collaborative partnerships at the provincial level. One of the most exciting achievements since the signing of the Framework Agreement is the increase in collaboration happening at the regional level.

There are several benefits to these new and evolving partnerships among First Nations, Regional Health Authorities and the FNHA. They allow First Nations communities to leverage the provincial health system in new and exciting ways, help align health care priorities and community health plans and better coordinate and integrate programs and services.

These partnerships offer Regional Health Authorities a single venue to work with the diverse Nations in each region. They enable First Nations to have greater influence over programs, services, planning and funding decisions of the Regional Health Authority. They promote greater leveraging of resources and the creation of a shared agenda and actions to improve First Nations health.

Regional processes will ensure that successful communication, collaboration and planning are achieved to improve coordination of efforts in developing innovative service delivery models at local and regional levels. Partnership Accords have been signed in all five regions of the province, with each document laying out unique plans, initiatives, and agreements between the First Nations and the Health Authorities in their respective territories.

Fraser Partnership Accord

Signed in December 2011, the Fraser Partnership Accord was the first of its kind in the province. The vision behind the signing was blending the best of two worlds in health – modern medicine and ancestral teachings and ways.

The Accord was signed by Fraser Health and the Fraser Salish Regional Caucus, which provide political and technical leadership to the Salish Nations. One of the key commitments in the Partnership Accord is the establishment of an Aboriginal Health Steering Committee. This committee will serve as a forum for joint efforts on First Nations and Aboriginal health priorities, policies, budgets and services in the Fraser Region.

The Accord calls for improvements in service delivery through more collaboration between Fraser Health and the region's First Nations Health Centres. The Accord also directs cooperative work with community health leaders to develop more culturally appropriate health strategies.



From left to right: Chief Willie Charlie - representative for the independent Fraser Salish communities; Chief Maureen Chapman – representative for Stó:lō Nation Chiefs Council, Dr. Nigel Murray – President & CEO, Fraser Health; Grand Chief Doug Kelly – representative for the Stó:lō Tribal Council and FNHC Chair.

“OUR APPROACH TO HEALTH AND WELL-BEING IS, MORE THAN ANYTHING, COMMUNITY-BASED. FIRST NATIONS AND ABORIGINAL PEOPLES HAVE A GOOD UNDERSTANDING OF THEIR HEALTH CHALLENGES AND GOALS, AND THIS PARTNERSHIP WITH FRASER HEALTH WILL HELP US REACH THOSE GOALS SOONER.”

Chief Willie Charlie, representative for the independent Fraser Salish communities.

“FRASER HEALTH IS COMMITTED TO WORKING COLLABORATIVELY WITH THE FRASER SALISH REGIONAL CAUCUS TO IMPROVE ABORIGINAL HEALTH SERVICES DELIVERED WITHIN THE FRASER REGION. THIS PARTNERSHIP WILL ASSIST FIRST NATIONS COMMUNITIES IN GOVERNING THEIR OWN HEALTH INITIATIVES TO IMPROVE THE LIVES AND THE HEALTH OF THE PEOPLE IN FIRST NATIONS COMMUNITIES.”

Dr. Nigel Murray, president and chief executive officer of Fraser health.



Left to right holding copies of the Accord: VCH Board Chair Kip Woodward, FNHA Board Vice-Chair, Pierre Leduc and Ernest Armann, Chair of Vancouver Coastal Regional Caucus.

“VANCOUVER COASTAL HEALTH IS COMMITTED TO IMPROVING THE HEALTH OF FIRST NATIONS AND ABORIGINAL PEOPLE AND THIS CAN ONLY BE DONE IN PARTNERSHIP WITH THE COMMUNITY. THE PARTNERSHIP ACCORD WILL STRENGTHEN THE RELATIONSHIP WE HAVE WITH FIRST NATIONS AND WILL FOSTER GREATER SELF-DETERMINATION FOR FIRST NATIONS COMMUNITIES OVER THEIR HEALTH CARE. WE LOOK FORWARD TO FINDING CREATIVE SOLUTIONS AND APPROACHES AS WE EMBARK ON THIS NEW RELATIONSHIP.”

Dr. David Ostrow, President and Chief Executive Officer of Vancouver Coastal Health.

Vancouver Coastal Partnership Accord

On May 16, 2012, the Vancouver Coastal Partnership Accord was signed by the Vancouver Coastal Regional Caucus, the *interim* First Nations Health Authority, and Vancouver Coastal Health. The Accord created a new path to improving health outcomes, programs, and services for First Nations in the Vancouver Coastal region.

Specific initiatives in the Partnership Accord include:

- The establishment of an Aboriginal Health Steering Committee as a forum for partnership, collaboration, and joint efforts on First Nation and Aboriginal health priorities, policies, budgets, programs and services in the Vancouver Coastal region.
- The development of an Urban Health Strategy that gives First Nations and Aboriginals a voice in the design of culturally relevant services and offers VCH guidelines and policies to incorporate specific traditional protocols and practices in the entire organization with the goal of supporting and improving services.
- The creation of a strategic Aboriginal Health and Wellness Plan for the Vancouver Coastal region with concrete milestones and deliverables.



Left to right: Shana Manson, Coast Salish FNHC Vancouver Island Regional Health Caucus Representative, James Wilson, Kwakwaka'wakw FNHC Vancouver Island Regional Health Caucus Representative, Cliff Atleo, Nuu-chah-nulth FNHC Vancouver Island Regional Health Caucus Representative, Howard Waldner, VIHA CEO, and Don Hubbard, Chair of VIHA Board of Directors.

Vancouver Island Partnership Accord

The signing of the Vancouver Island Partnership Accord took place on the evening of May 14, 2012, in a ceremony during the fifth annual provincial *Gathering Wisdom for a Shared Journey* forum. The focus of this Accord is developing strong processes to support collaboration, innovation and improved health outcomes.

Building on the pillar of reciprocal accountability, the Accord commits the parties to work together to achieve shared decision-making. It will increase the influence of First Nations in decisions relating to health services delivered within the Vancouver Island Region. It also sets out a mutual commitment to improve the well-being of all First Nations living in the Vancouver Island region regardless of Nationhood, status, and location.

New joint activities between the Vancouver Island Caucus and Vancouver Island Health Authority under the Accord will include the development of measurable success indicators to gauge progress. It also provides for a review of Vancouver Island Health Authority's Aboriginal Health Plan and First Nations Community Health and Wellness Plans to achieve better coordination.

“THIS IS A VERY IMPORTANT MOMENT FOR VANCOUVER ISLAND FIRST NATIONS PARTNERING WITH VANCOUVER ISLAND HEALTH AUTHORITY TO PROVIDE IMPROVED HEALTH OUTCOMES FOR OUR PEOPLE.”

Cliff Atleo, FNHC Vancouver Island Representative



In May 2012, the Northern Health Authority and the Northern Regional Health Caucus of the interim First Nations Health Authority signed a Partnership Accord. The ceremony was blessed with the blowing of white swan down by representatives from the Nisga'a Nation.

Northern Partnership Accord

The Northern Regional Health Caucus, interim First Nations Health Authority and Northern Health signed the Northern Partnership Accord on May 16 2012. The Accord lays the groundwork for innovations in health service delivery and the creation of a more integrated, culturally appropriate, safe, and effective health system.

Included in the agreement is the development of a joint Northern Health and Northern First Nations Health and Wellness Committee and Plan that will identify the health needs of First Nations in the North, find solutions, and use measurable indicators to track its success. The Northern Partnership Accord acknowledges the right of self-governance for each First Nation, and the partnership between Northern Health, the interim First Nations Health Authority and the North Regional Health Caucus to close the gaps and remove barriers to accessing and improving services.

Partners will work to increase understanding of First Nations traditions, customs and protocols in the entire Northern Health system including incorporating a Cultural Responsiveness Strategy. Other joint initiatives include coordination and alignment of planning and service delivery, additional recruitment and retention of health professionals in the North, and improving coordination of primary care services, access to services in remote communities and communications.

“OUR NORTHERN CAUCUS HAS COME TOGETHER AS ONE VOICE REPRESENTING ALL VIEWPOINTS AND IN CLOSE COLLABORATION WITH NORTHERN HEALTH CREATED THIS ACCORD THAT WILL PROVE TO OFFER CONCRETE OUTCOMES TO NORTHERN FIRST NATIONS AND POSITIVELY IMPACT ALL RESIDENTS OF THE NORTH.”

Marjorie McRae, Northern Regional Health Caucus Representative

“THE MOST IMPORTANT WORD IS ‘PARTNERSHIP,’ WE CAN DO MORE IN PARTNERSHIP THAN WE CAN ALONE. I BRING OUR COMMITMENT TO YOU, WE ARE HERE TO LISTEN, LEARN AND ACTIVATE.”

Cathy Ulrich – CEO, Northern Health.



“THE HEALTH OF FIRST NATIONS PEOPLE WITHIN OUR REGION IS A KEY PRIORITY FOR INTERIOR HEALTH. TODAY’S SIGNING IS AN IMPORTANT STEP FORWARD AS WE CONTINUE TO COLLABORATE WITH THE COMMUNITIES AND BUILD ON THE SUCCESS OF OUR ABORIGINAL HEALTH TEAM, TO ADDRESS HEALTH DISPARITIES AND ENSURE ACCESS TO CULTURALLY APPROPRIATE CARE.”

- Norman Embree, Board Chair, Interior Health

Interior Region Partnership Accord signing ceremony. L-R: Interior Health CEO Robert Halpenny, Interior Health Board Chair, Norman Embree, Secwepemc Nation representative Kukpi7 Wayne Christian, Nlaka’pamux Nation representative, Ko’waintco Michel.

Interior Partnership Accord

First Nations in the BC Interior, the regional FNHC representatives and the Interior Health Authority signed the Interior Partnership Accord on November 14, 2012. The Accord prepares all parties to work together in new ways based on values of ‘collaboration, trust, inclusion, celebration and innovation’. The Accord signals the future development of culturally appropriate coordinated and integrated First Nations health and wellness system and lays out a number of achievable goals, action plans, accountability structures and measurable indicators to gauge its success.

Actions stemming from the Accord will result in improved quality, accessibility, delivery, effectiveness, and efficiency of health care programs and services. It will also reflect the cultures and perspectives of Interior First Nations.

Specific Interior Partnership Accord Action Plan items include:

- Forming a Health and Wellness Committee comprised of senior management from both parties.
- Developing a consistent and harmonized planning and evaluation framework.
- Developing Regional Health and Wellness plans that build upon Community/Nation Health Plans with set standards, targets, outcomes and measurements.
- Develop service delivery systems to better reflect the needs of First Nation people in the Interior Region.
- Develop a comprehensive health human resources strategy.
- Establish common indicators, targets, milestones, and benchmarks.

“THIS IS ONLY THE BEGINNING OF THE CHANGES THAT WILL LEAD US TO OUR VISION OF HEALTHY, SELF-DETERMINING, VIBRANT, BC FIRST NATIONS CHILDREN, FAMILIES AND COMMUNITIES. THE INTERIOR PARTNERSHIP ACCORD BUILDS ON A NUMBER OF HISTORIC AGREEMENTS AND INCLUDES THE PRINCIPLES THAT INTERIOR NATIONS ARTICULATED IN THEIR UNITY DECLARATION IN 2010, THAT WE HAVE A RESPONSIBILITY TO CARE FOR OUR PEOPLE IN WAYS THAT MAKE SENSE TO US AND TO GOVERN OVER THE TERRITORIES THAT THE CREATOR GIFTED US WITH.”

- Gwen Phillips, Ktunaxa Nation. First Nations Health Council Interior caucus representative



5) Community Engagement: B

"IT'S ABOUT FIRST NATIONS CITIZENS UNDERSTANDING THEIR RESPONSIBILITY AS AN INDIVIDUAL, IT'S ABOUT FIRST NATIONS AND ABORIGINAL FAMILIES UNDERSTANDING THEIR RESPONSIBILITIES AS A FAMILY, OUR COMMUNITIES UNDERSTANDING THEIR RESPONSIBILITIES AS A COMMUNITY, AND OUR NATIONS TAKING THEIR RESPONSIBILITY FOR THEIR DECISIONS AS A NATION. IT'S LESS ABOUT WHAT CANADA HAS TO SAY, IT'S LESS ABOUT WHAT THE PROVINCE HAS TO SAY, IT'S MORE ABOUT WE HAVE TO SAY AND WHAT WE ARE GOING TO DO ABOUT RESOLVING OUR ISSUES AND TAKING ADVANTAGE OF THE OPPORTUNITIES."

- Grand Chief Doug Kelly, Chair FNHC

The Need for Community Engagement

Historically, BC First Nations communities have not been actively encouraged or resourced by governments to work together. Management of Health Canada programs and services at the community level through transfer agreements provided little incentive or encouragements for communities to come together to plan, collaborate or build relationships with one another.

Initially, federal and provincial partners were not supportive of the allocation of funds for the intensive engagement proposed by the FNHC. However, the historic failure to secure community support for other province-wide processes with respect to devolution led governments to reevaluate this perspective. Undertaking large-scale engagement with BC First Nations guided much of the subsequent activity and ultimately, funding was made available to conduct further extensive engagement that made the process a success.

When the Health Plans were signed, there were no effective means in place for the FNHC to communicate directly with communities in a practical way. Likewise there were no effective means for communities to share experiences, knowledge, innovations, lessons and issues. First Nations communities were in need of mechanisms that made use of economies of scale, joint decision-making, advocacy and peer support.

Comprehensive Engagement Networks

Essential to the success of BC First Nations health care reform is a consistent 'Comprehensive Engagement Process.' Through a number of initiatives, sub-groups and committees, the FNHA and FNHC maintain the approach of being 'Community-Driven, Nation-Based.' Through Community Engagement Hubs, Regional Caucus Sessions, the annual Gathering Wisdom for a Shared Journey forums and other mechanisms,

Building a Common Voice

The commitment to offer the time and resources needed to undertake intensive engagement was a key factor in successfully informing and engaging leadership.

Partnerships amongst BC First Nations have been critical to the success achieved through the health transformation process. The most important partnerships, are the partnerships that BC First Nations are establishing amongst themselves.

space is created for each First Nations community's voice is at the table. This comprehensive engagement process is a cornerstone of the health systems transformation process, with communities leading the discussion.

Regional Caucuses and Tables

Regional engagement amongst First Nations Chiefs, health leaders, and health directors was developed through and is supported by Regional Caucuses. The purpose and governance of these forums continues to evolve as the Terms of Reference, technical support and overall conversation in the region develops. In general terms, Regional Caucuses provide a forum for leadership to provide input and direction into the shaping and activities of the new province-wide First Nations health governance structure, and also support First Nations to advance the implementation of agreements with the Regional Health Authority.

Regional Caucuses:

- Engage and share information;
- Make appointments to the FNHC;
- Receive reports from the FNHC and FNHA;
- Provide guidance and feedback to the FNHC and FNHA;
- Provide direction for the development and implementation of initiatives with the Regional Health Authority;
- Provide guidance and leadership to the redesign of programs and services; and,
- Identify and oversee regional health initiatives and innovations with the Regional Health Authority or amongst First Nations in the region.





Ceremonial blowing of down (feathers) at Gathering Wisdom V by a member of the Northern Region.

Gathering Wisdom for a Shared Journey

Gathering Wisdom for a Shared Journey events are unique in bringing together representation from all BC First Nations for collective decision-making on their health systems. When the FNHC was established, the first task was to engage with BC First Nations to seek direction on how to move forward with the Health Plans. This resulted in the FNHC hosting the first Gathering Wisdom for a Shared Journey forum in May 2007.

At the initial forum, participants made it clear that First Nations communities needed resources in order to effectively engage with each other and with the government partners. The communities expressed a need for opportunities to be able to work together, share experiences and learning, and to provide support to one another. Communities also said that the Tripartite partners needed to ensure they took a holistic and culturally-based approach to the actions in the plan and needed to strengthen the role of First Nations in decision-making.

Since the first Gathering Wisdom forum in April 2007, the event has grown exponentially with 800 delegates attending Gathering Wisdom V in May of 2012.

Gathering Wisdom for a Shared Journey has provided a forum for First Nations leaders, Health Directors and community representatives to dialogue with each other and partner governments. The forum has been a key mechanism for building relationships and shared understandings. Learning from Indigenous brothers and sisters who have taken responsibility for the health of their citizens is a cornerstone of the annual forum.

As the engagement process has evolved, so too has the role of the forum as is related to political decision-making. As the new BC First Nations health system progresses, the Gathering Wisdom forums continue to enjoy tremendous support from BC First Nations as a way to engage, plan and move forward on designing a health system that meets their needs.

Community Engagement Hubs - Partnership Amongst BC First Nations Communities

Health Directors had made it very clear at the outset that implementing the Health Plans was not something that they could do “off the sides of their desks.” Taking capacity out of the communities to implement the health plans was not an option and progress must not be made at the expense of community services. To create a forum for partnership and collaboration among communities, the FNHA provided resources to groups of First Nations through a new vehicle - Community Engagement Hubs.

Community Engagement Hubs (Hubs) are groups of First Nations communities who agree to work together to meet their local health priorities and support health plan implementation. The formation of Hubs encourages natural collaborations based on tribal and geographical factors, by providing resources to existing capacity. Hubs were not intended to be ‘structures’ – but a means for communities to communicate, collaborate and plan. Through the formation of Hubs, communities now had in place a vehicle to discuss common issues, and strategies to address those issues.

Hubs have also provided a means for structured communication and information sharing between the FNHA and communities. Hubs also provide a contact point for regional health authorities to more effectively collaborate with communities. Never before had proactive resources been provided to communities for health planning and engagement.

Given their diversity, the formation of Hubs was a remarkable achievement for BC First Nations communities and was a major step in supporting continued collaboration, communication and coordination among communities. In year one 2007-2008, 10 community engagement hubs were established which involved 100 First Nations communities. By March 2012, 32 Hubs representing 175 of 203 communities (86%) were in place. Today Hubs represent the single largest FNHA budget item at \$4.3 million dollars annually. Hub resources represent a proactive investment in health capacity and have resulted in a number of benefits:

“AS INDIVIDUAL COMMUNITIES, WE STAND ON OUR OWN AND OUR VOICE IS SMALL . . . [BUT] BY TEAMING UP WITH OTHER HUBS, WE BEGIN TO KNIT THE REGION TOGETHER.”

- Respondent, CeH evaluation

“THE HUB MODEL HAS AN IMMEDIATE AND DIRECT BENEFIT TO COMMUNITIES, CREATING THE RESOURCES AND TIME NEEDED TO ‘RISE ABOVE’ DAILY HEALTH PRIORITIES AND URGENT NEEDS WHILE ACTIVELY EXPLORING VARIOUS PATHWAYS FOR POSITIVE CHANGE.”

- Respondent, CeH evaluation

Benefits of Community Engagement Hubs

Providing a mechanism for communities to work together

Hubs enable a group of communities (usually through their mandated community health organizations) to come together to discuss various common issues and to find common solutions. Collaboration and joint planning create efficiencies that free up resources for improved health services generally. For example, where it may not be feasible to have a mental health expert in every community, the hub provides space for communities to contribute towards one expert available to serve the member communities of the hub. In this way, collaboration and resource sharing between the nations in a hub can fill health gaps that otherwise would not be addressed.



Boothroyd community health fair, bringing health services and information to Fraser Canyon communities.



14 Nuu-chah-nulth communities work collaboratively to develop community health plans.

Sharing Knowledge and Expertise

Within any hub, there is a wide range of skills and experience among the member communities: some may have significant management or other expertise; some may have developed, tried, and tested new ways of doing things that are producing good outcomes; some may have successfully formed relationships with organizations and allies that have resulted in service improvements; some may have completed Community Health and Wellness Planning processes that is a best practice within the region; and, some may have developed resources and informational material for the families, schools and Band Councils in their communities. Hubs provide a mechanism for communities to share this knowledge, expertise, and innovations with one another.



Seaplane at Old Massett, Hubs have helped remote communities to work together and proactively plan to enhance access to health services for citizens.



The Northwest Health Hub provides 9 northern communities the opportunity to share issues and challenges and work together for joint solutions.



With hundreds of kilometres between member communities, the Treaty 8 hub focuses on create

Improving the linkage with the Regional Health Authority

Regional Health Authorities have a responsibility to provide health services to First Nations on and off reserve. They often find it difficult to engage with First Nations and to develop solutions for service delivery that will work for First Nations communities. Until quite recently, there were very limited connections between First Nations and the Regional Health Authorities. Lack of resources, lack of political will and a long history or habit of non-engagement and jurisdictional disputes all contributed to a lack of communications and meaningful engagement. The hubs provide a forum for Regional Health Authority personnel to meet with a group of linked communities, to look at ways of better serving those communities. This includes ways to proactively address any recurring issues with respect to the treatment of First Nations in the services offered by the Regional Health Authority.

Peer Support

Many First Nations communities are remote, and as a result the health centre workforce in the community is often isolated. Health professionals, Managers and health workers often do not have opportunity to speak with their peers from other health centres to share issues, challenges and innovations – and to give and receive support to each other. Involvement in the hub provides this opportunity.

Improving communications

A key function of hubs is as a communications vehicle – a network through which the FNHC, FNHA, and FNHDA can roll-out information and updates with respect to the health systems transformation process. They are also an effective way for the FNHC, FNHA, and FNHDA to quickly access information about what is happening on-the-ground. Hubs also provide a way for the communities within the hub to communicate with one another (some Hubs have started their own newsletters and websites), and for hubs to communicate with one another, expanding collaboration across hubs.

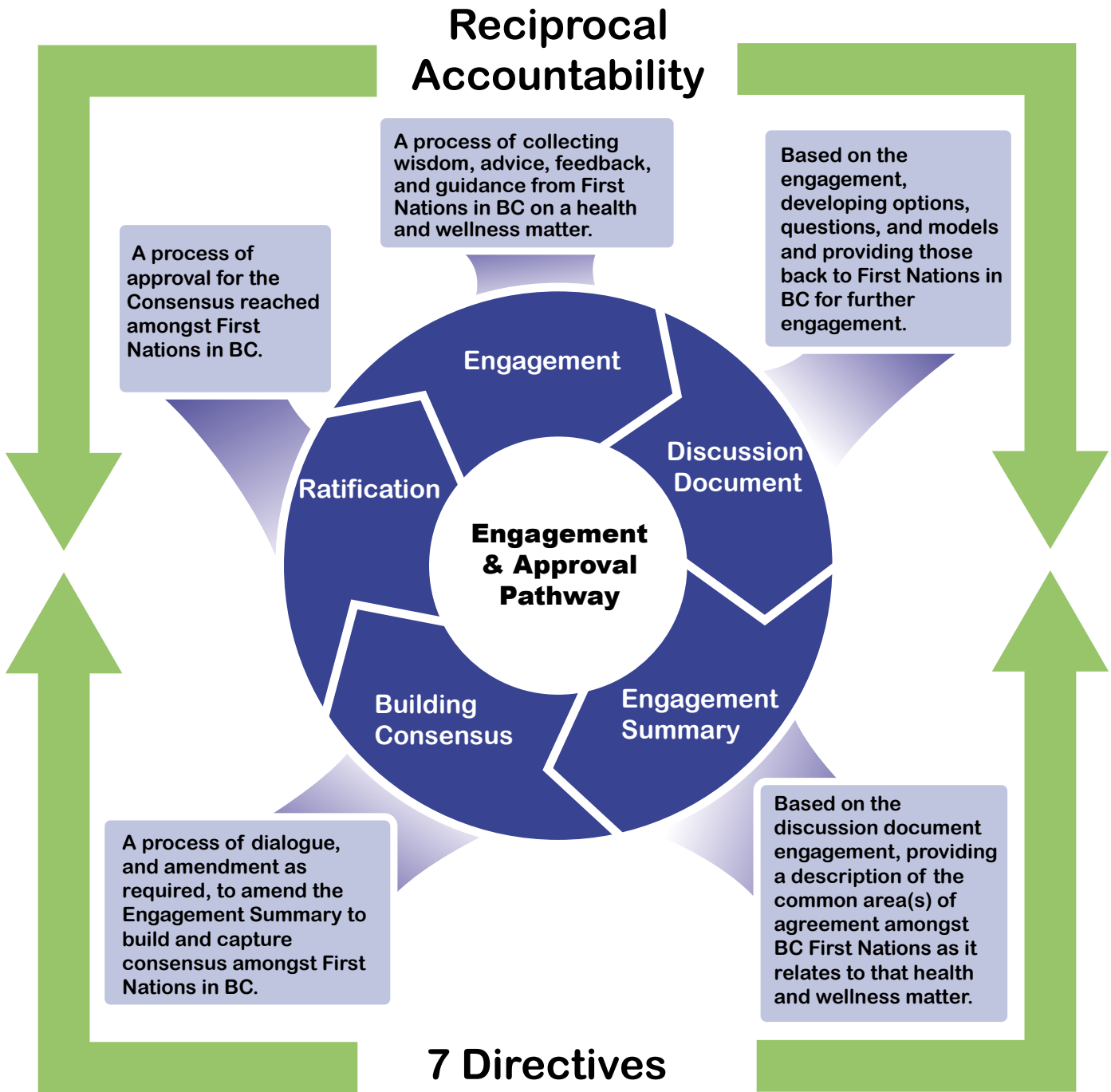


Delegates at the Gathering Wisdom for a Shared Journey Forum review final materials prior to a vote by leadership.

Community Engagement Pathway and Consensus Building Process

Through the extensive effort to create and deploy an engagement network to inform health systems transformation and the health governance structure, the conversation amongst First Nations has grown from one of information-sharing and information-gathering, to one where First Nations seek to make informed decisions about the process. A process for informed decision-making and consensus-building has emerged. First Nations called upon the FNHC to put this on paper – to design and describe the process for community

engagement, consensus-building, and informed decision-making. As per this direction, the FNHC released the Engagement and Approval Pathway. The pathway set out a consistent process to be used to gather First Nations input and guidance for strategic-level decisions of the First Nations health governance structure. These high-level strategic decisions concern the general direction, long-term goals, philosophies, and values of the organization.



The Engagement and Approval Pathway was first tested in 2011, through the first Workbook process (see opposite page).

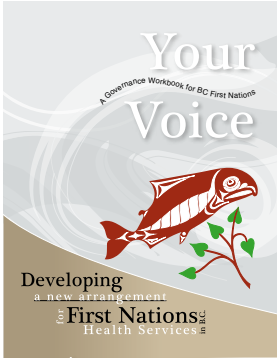
Through adopting the Consensus Paper 2011: BC First Nations Perspectives on a New Health Governance Arrangement, First Nations provided the marching orders for the work to come. They

adopted and set out the roles and responsibilities of the FNHC, FNHA, FNHDA and Regional Caucuses, and directed the transition of the FNHS to the iFNHA. They agreed to a definition and processes of Reciprocal Accountability. They endorsed the signing of the Framework Agreement. Importantly, they set the 7 Directives – the standards that the new health governance transformation process must meet:



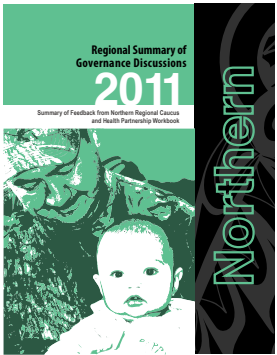
ENGAGEMENT

A series of 120 regional and sub regional meetings held across BC from 2008-2011 on the topic of Health Governance.



DISCUSSION DOCUMENT

First Nations in community engagement hubs, sub-regions, and Regional Caucuses reviewed and completed key background information, and questions with respect to the First Nations health governance structure. This was the Discussion Document step of the Pathway.



ENGAGEMENT SUMMARY

The Workbook feedback was summarized in a series of five regional summary reports, circulated to First Nations in regions for review and feedback. This was the Engagement Summary step of the Pathway.



CONSENSUS BUILDING

All five regional summary reports were rolled into one single Consensus Paper, containing areas of common agreement among BC First Nations. This was the Consensus Building step of the Pathway. The discussion document was circulated to First Nations for review and minor dialogue and amendment.



RATIFICATION

Finally, that Consensus Paper was adopted by resolution of BC First Nations at Gathering Wisdom for a Shared Journey IV in May 2011. Of the Chiefs attending the meeting (87% of First Nations in BC sent a Chief or delegated leader to the assembly) 87% voted in favour of taking over health service delivery.



Directive #1: Community-Driven, Nation-Based

- The community-driven, nation-based principle is overarching and foundational to the entire health governance arrangement
- Program, service and policy development must be informed and driven by the grassroots level
- First Nations community health agreements and programs must be protected and enhanced
- Autonomy and authority of First Nations will not be compromised

Directive #3: Improve Services

- Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into all health programs and services that serve BC First Nations
- Improve and revitalize the Non-Insured Benefits program
- Increase access to primary care, physicians, nurses, dental care and other allied health care by First Nations communities
- Through the creation of a First Nations Health Authority and supporting a First Nations population health approach, First Nations will work collectively to improve all health services accessed by First Nations
- Support health and wellness planning and the development of health program and service delivery models at local and regional levels

Directive #2: Increase First Nations Decision-Making and Control

- Increase First Nations influence in health program and service philosophy, design and delivery at the local, regional, provincial, national and international levels
- Develop a wellness approach to health including prioritizing health promotion and disease and injury prevention
- Implement greater local control over community-level health services
- Involve First Nations in federal and provincial decision-making about health services for First Nations at the highest levels
- Increase community-level flexibility in spending decisions to meet their own needs and priorities
- Implement the OCAP (ownership, control, access and possession) principle regarding First Nations health data, including leading First Nations health reporting
- Recognize the authority of individual BC First Nations in their governance of health services in their communities and devolve the delivery of programs to local and regional levels as much as possible and when appropriate and feasible

BC First Nations 7 Directives



Directive #4: Foster Meaningful Collaboration and Partnership

- Collaborate with other First Nations and non-First Nations organization and governments to address social and environmental determinants of First Nations health (e.g. poverty, water quality, housing, etc.)
- Partnerships are critical to our collective success. First Nations will create opportunities through working collaboratively with federal, provincial, and regional partners
- Foster collaboration in research and reporting at all levels
- Support community engagement hubs
- Enable relationship-building between First Nations and the regional health authorities and the First Nations Health Authority with the goal of aligning health care with First Nations priorities and community health plans where applicable

Directive #6: Be Without Prejudice To First Nations Interests

- Not impact on Aboriginal Title and Rights or the treaty rights of First Nations, and be without prejudice to any self-government agreements or court proceedings
- Not impact on the fiduciary duty of the Crown
- Not impact on existing federal funding agreement with individual First Nations, unless First Nations want the agreements to change

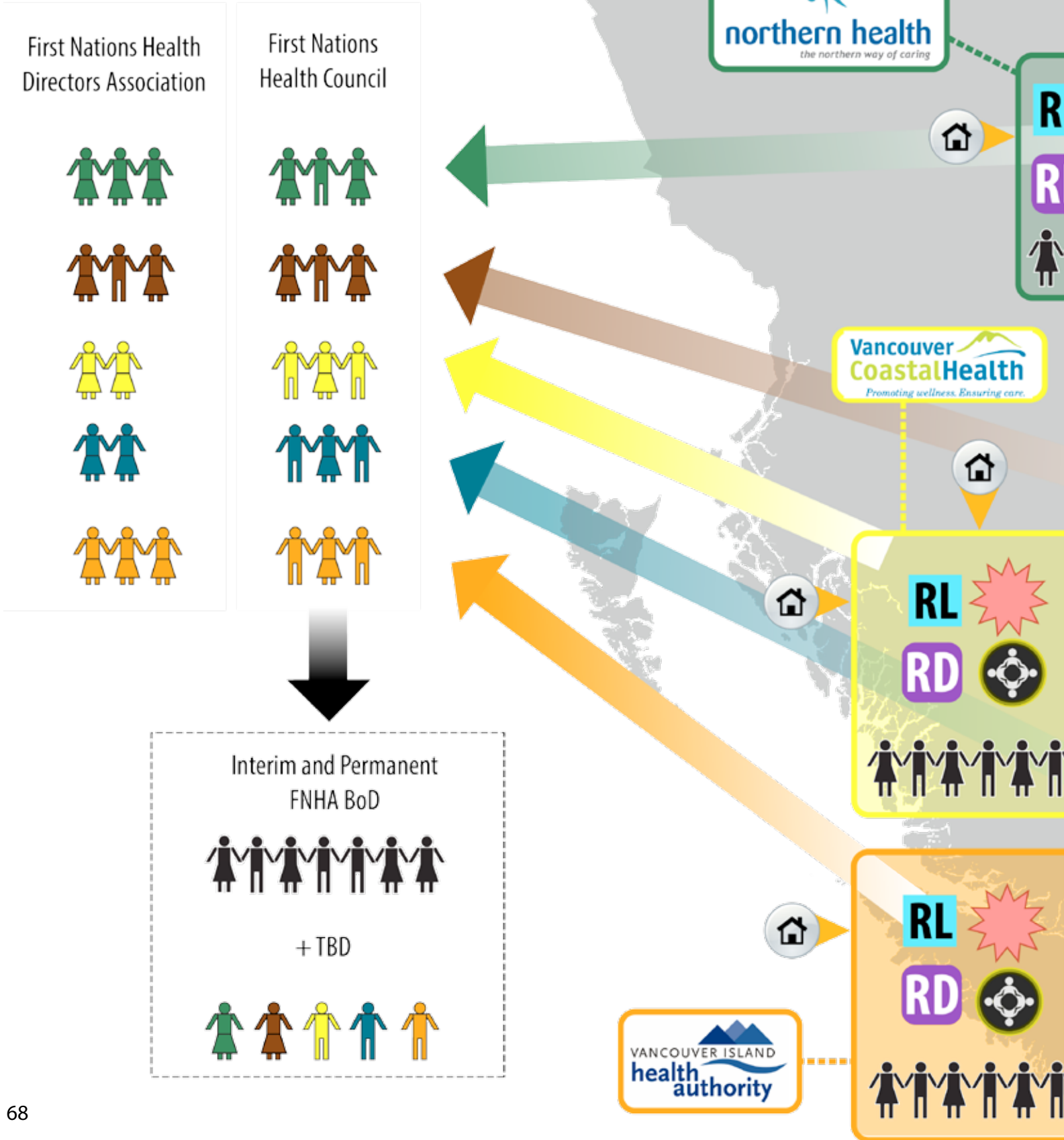
Directive #5: Develop Human and Economic Capacity

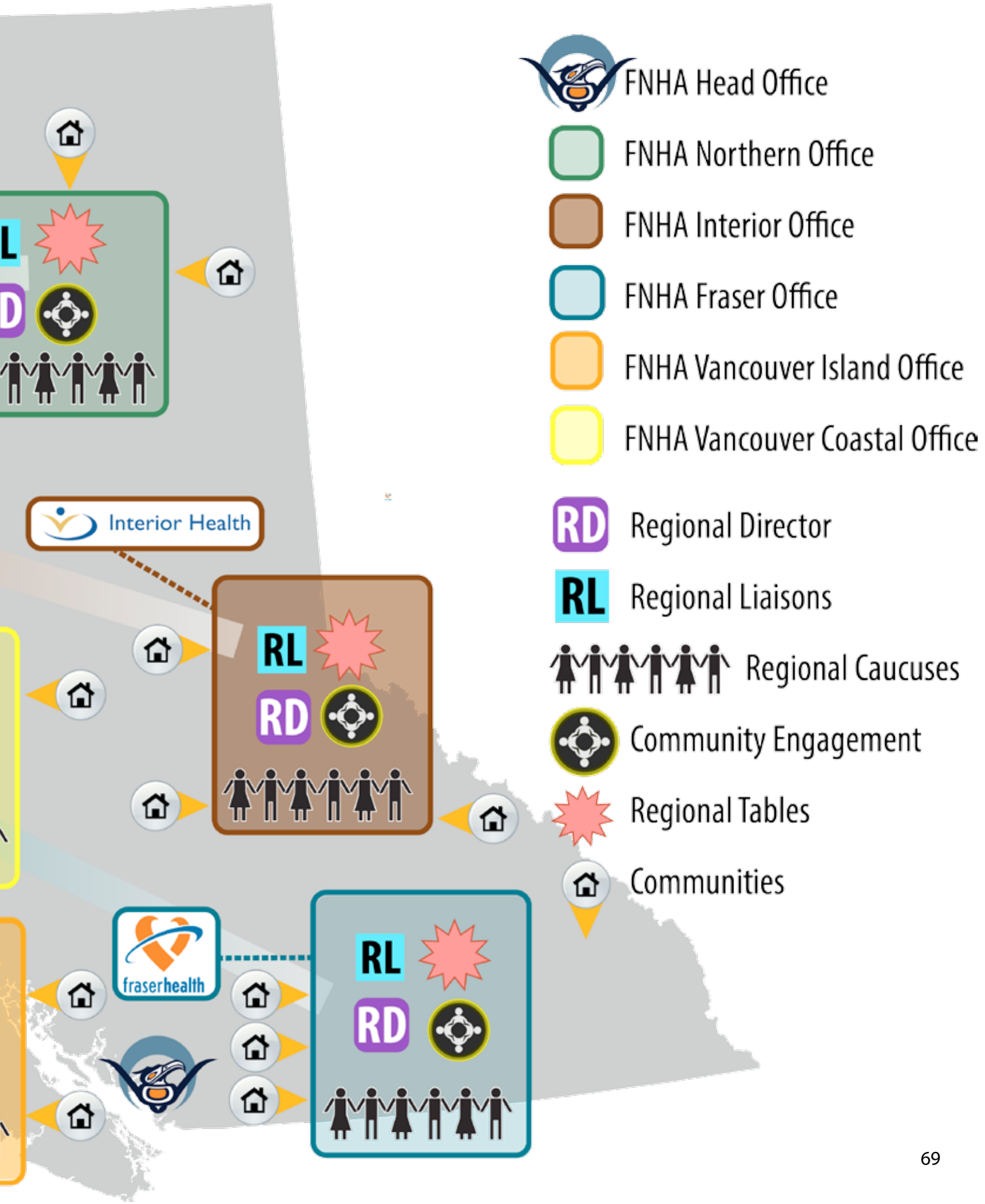
- Develop current and future health professionals at all levels through a variety of education and training methods and opportunities
- Result in opportunities to leverage additional funding and investment and services from federal and provincial sources for First Nations in BC
- Result in economic opportunities to generate additional resources for First Nations health programs

Directive #7: Function At A High Operational Standard

- Be accountable, including through clear, regular and transparent reporting
- Make best and prudent use of available resources
- Implement appropriate competencies for key roles and responsibilities at all levels
- Operate with clear governance documents, policies, and procedures, including for conflict of interest and dispute resolution.

Comprehensive decision-making and engagement network.





FNHA Head Office



FNHA Northern Office



FNHA Interior Office



FNHA Fraser Office



FNHA Vancouver Island Office



FNHA Vancouver Coastal Office



Regional Director



Regional Liaisons



Regional Caucuses



Community Engagement



Regional Tables



Communities

Interior Health





“SOMETIMES THE UNKNOWN CAN BE A BIT SCARY. WHAT OFTEN PARALYZES US AS FIRST NATIONS IS FEAR, BUT WITH ALL THE PREPARATION WE HAVE DONE IN THE CONSULTATION PROCESS WE ARE READY. WE ARE THE ONES THAT CAN MAKE THE CHANGE.”

Chief Cheryl Casimer, St. Mary's Indian Band

The Workbook process was again employed in 2012. This led to the adoption of the Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure by BC First Nations leaders at Gathering Wisdom for a Shared Journey V. Leadership voted 93% in favour of the proposed governance structure and establishment of a permanent First Nations Health Authority. Through adopting the Consensus Paper 2012, BC First Nations committed to a change management process characterized by a Transition phase, and then a Transformation phase. They approved the transition of the iFNHA to a permanent FNHA and directed that the FNHA employ a holistic health governance approach that

utilizes corporate, non-profit, and legislative components. BC First Nations also established a new governance (Board of Directors) structure for the FNHA, and adopted competencies for those Board members.

Planning for Community Engagement

As described, there is an extensive engagement network in place, with many moving parts. In order to ensure a consistent and streamlined approach to community engagement, effective use of available resources, and that First Nations communities aren't overburdened with engagement requests and meetings, the FNHC, FNHA and FNHDA have agreed-upon a collaborative process for community engagement planning:

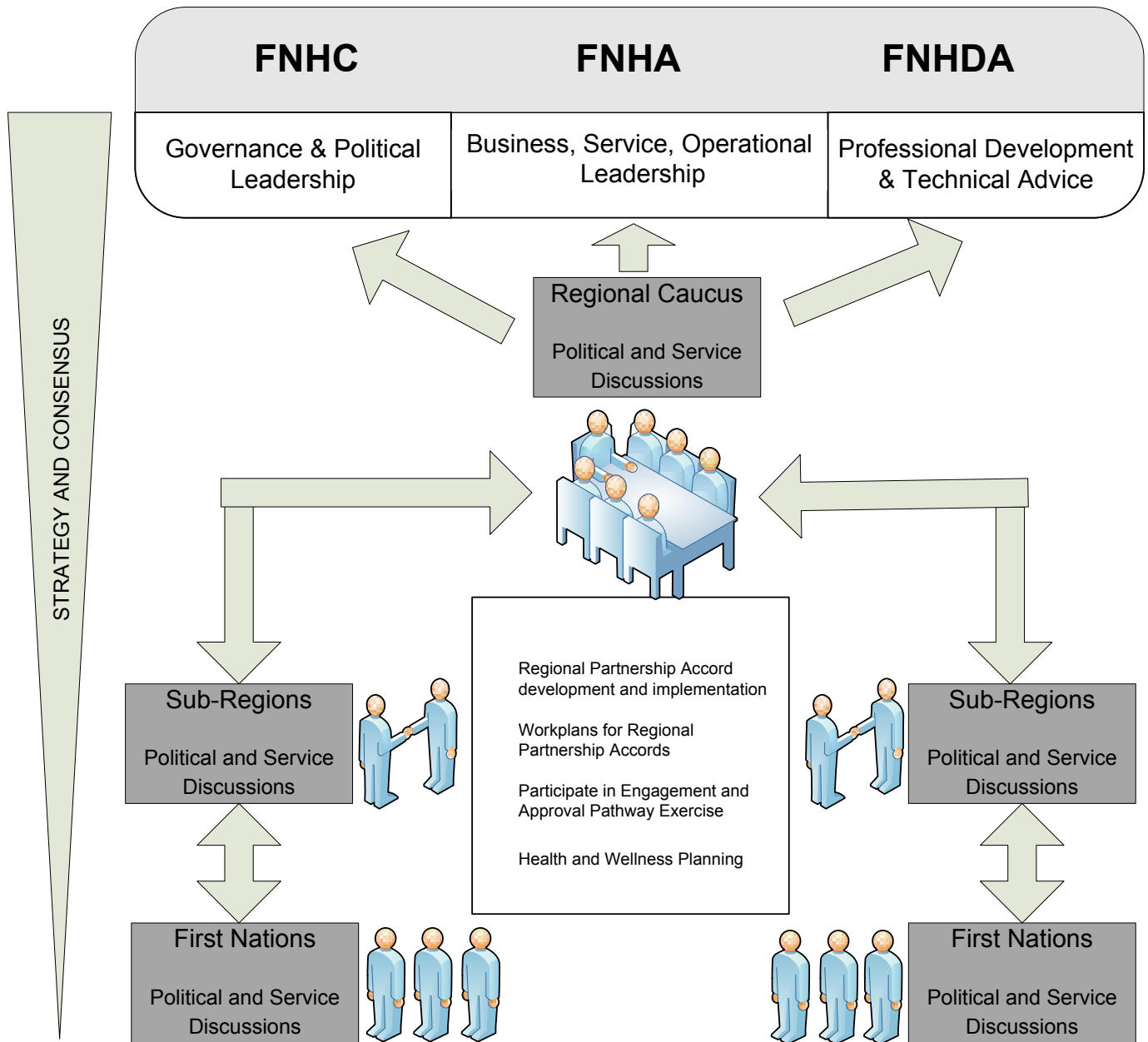


To achieve the change that is occurring two-way communications is essential. Regional Caucuses continue to meet to receive information and provide guidance. Pictured here are members of the Interior Caucus in meeting.

RULES OF ENGAGEMENT

1. The FNHC, FNHA and FNHDA will all use a shared network for community engagement administered by the FNHA (including Regional Caucuses and Community Engagement Hubs)
2. The FNHC, FNHA, and FNHDA will all employ the Engagement & Approval Pathway in strategic-level community engagement activities.
3. The FNHC will largely drive the planning for community engagement, with the FNHA and FNHDA following the planning established by the FNHC. Each year, the FNHC will adopt an FNHC Community Engagement Plan (working in collaboration with the FNHA to ensure the Plan is financially feasible). Once adopted, the plan will be shared with the FNHA and FNHDA, who will each develop their community engagement priorities consistent with the schedule and priorities established in the FNHC's Community Engagement Plan. The FNHC, FNHA and FNHDA will discuss one another's annual priorities at the Collaboration Committee to ensure coordination.
4. Prior to each round of Regional Caucus sessions, the FNHA and FNHDA will bring any agenda items forward to the FNHC via the Collaboration Committee for discussion. The Parties will work together to make appropriate space for these agenda items on the Regional Caucus agendas or make plans to add an extra day onto the Regional Caucus meeting specifically for business of the FNHA and/or FNHDA.

Consensus leadership and engagement model





Communications

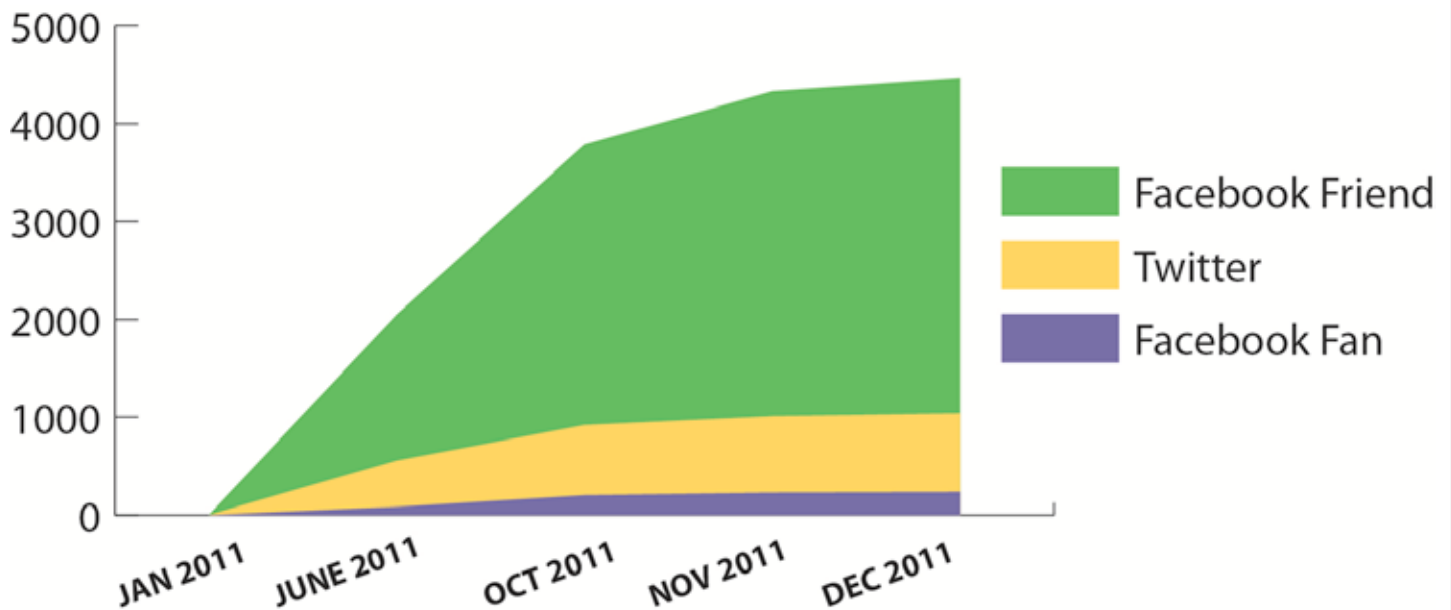
'Communication is key' has been expressed repeatedly by First Nations leaders in every corner of BC. This is especially true when undertaking major reforms to systems as complex and vital as health services. For an initiative as ambitious as a change in health governance, there has been a critical need to communicate what is being proposed, the process by which decisions are made and other important issues. This ability to ensure that Chiefs have information that is relevant and timely has significantly supported the process. To support a consistent strategy and messaging, the FNHA has a central Communications Department that also supports the communications of the FNHC and FNHDA. This Department develops the overall communications strategies, and deploys the materials, tools, and supports for the implementation of that strategy. The central Communications Department draws upon the community engage-

ment network of hubs and Regional Caucuses to reach target audiences.

In addition to traditional newsletters and other forms of communiqué, extensive use of video and social media has also been key to successful communication. Twitter has been an important venue for engaging with organizations (First Nations, BC health organizations and other agencies). Facebook remains a forum for more grassroots engagement with participation from a large number of frontline First Nations health workers.

The Communications department has produced a wide range of products to support the work of the Community Engagement team and to provide Chiefs, Health Directors and others with information about the process.

Growth of Social Media



The FNHA is making use of social media to disseminate news and health information, maintaining a Twitter account, Facebook page, YouTube Channel and website. To date the website, www.fnhc.ca has generated over 2 million hits, the FNHC twitter feed has more than 1800 followers and the Facebook page has as many 'friends' as the system will permit.

Since beginning to work with social media in 2011 we have had significant growth in followers. This trend has continued and is a significant way of sharing information and receiving questions and feedback.

Social Media Do's:

- **Keep your health messages clear and consistent!** Make sure your health messages stay close to the goals and mandate of your organization
- **Don't let your social media platforms fade away!** It's common for extremely active Twitter accounts to update on an hourly basis (during peak hours of the work-day), anywhere from 1-5 times a day on Facebook pages, and twice a week for websites
- **Link your information!** Work to draw traffic back to your website or facebook page where you host more in depth information and resources
- **Use photos, videos and pictures.** A picture truly is worth a thousand words. Using visual images garners a different kind of attention than text-based updates; it often is considered exciting and more interesting
- **Avoid spamming your audience!** Keep the info relevant, and closely monitor your wall for spamming from external users.



FIRST NATIONS HEALTH COUNCIL

Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities



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Latest News

Watch our 'Implementing the Vision' Youtube video series for an introduction to the FNHC and FNHA!



[Watch Chapter One of 'Implementing the Vision' Here!](#)



FN Health Council
FNHC

FNHC "Transformative Housing - Shelter for Urban First Nations Mothers" Pg 16 [ow.ly/i2m3c](#) #bchousing #housingfirst
6 hours ago · reply · retweet · favorite

FNHC "To This Day Project" - a great #anti-bullying campaign video by BC Poet Shane Koyczan. [youtube.com/watch?v=Itun92...](#)
7 hours ago · reply · retweet · favorite

FNHC RT @ubcmdup: How #UBC's department of Emergency Medicine is supporting #rural docs in #BC. [ow.ly/i2kr6](#) #bchealth #meded
7 hours ago · reply · retweet · favorite

FNHC "Break down stigma of mental health issue" [ow.ly/hXIG3](#) #mentalhealth #mentalwellness #bchealth #cdnhealth
3 days ago · reply · retweet · favorite

The FNHA initially communicated in print through a newsletter; the Infobulletin. Written in a newsletter format the Infobulletin was produced from April 2008 to July 2012, its tone was factual and informational. In 2012 the infobulletin was replaced by *Spirit* magazine.

Spirit is released quarterly and has become a valuable tool for sharing information, celebrating successes, and supporting an emerging First Nations health and wellness network. The first issue of Spirit Magazine was released in the fall of 2012 with a print run of 3,000 which were distributed to First Nations, First Nations Health

Centres and through meetings. In addition, the magazine is available for download free and to date has had more than 6,000 downloads.

A 2010 survey of key target audiences sought to measure the effectiveness of communication efforts to date. The survey results provided important demographic information to support decision-making at the technical level. The survey also revealed key differences between Health Directors and Chiefs preferred methods of communications. The Communications Department has used the results as a foundation for continuous improvement.



6) Learning: A Key to Change

"THE GOVERNING BODY WAS TO ENSURE THAT WHEN STATEWIDE DECISIONS WERE MADE, IT WAS WITH THE FULL AUTHORITY OF THE REGIONAL HEALTH ORGANIZATIONS."

- Lanie Fox, Alaska Native Health Board



Although no precedent exists for this work in Canada, this journey has been informed by other Indigenous peoples worldwide, and particularly by Indigenous peoples in the US, Alaska, and New Zealand. A concerted effort has been made to learn as much as possible from those that have traveled a similar journey. These allies have been very generous with their time and knowledge, and we have drawn tremendous inspiration and strength from their processes.

From early in the process the FNHA and FNHC have worked to learn from international models of health governance that involve indigenous people. This learning has involved fact-finding trips, bringing in speakers and experts to work with the FNHA staff, as well as presenters at various gatherings.

Indigenous voices at Gathering Wisdom Forums

Gathering Wisdom III (November 3-5, 2009)

Indigenous Health Governance – Helping build appropriate and resilient Governance Structures for Improved Well-being and Health Outcomes

- Manuhua Barcham, PhD, Synexe Consulting Ltd., New Zealand.
- Paul L.A.H. Chartrand, Saskatchewan

Thinking About Indigenous Health Service Models

- Manuhua Barcham, PhD, Synexe Consulting Ltd., New Zealand.
- Alaska Tribal Health System: Introduction and Lessons Learned, Valerie Davidson, Senior Director, Alaska Native Tribal Health Consortium.

Gathering Wisdom IV (May 24-26, 2011)

Alaska Native Health Board Panel

- Lanie Fox, President/CEO Alaska Native Health Board.
- Andrew Jimmie, Vice-chair, Alaska Native Health Board.

US Self-governance panel

- Jim Roberts, Northwest Portland Area Indian Health Board
- Geoffrey Strommer, Hobbs Strauss & Co.
- Ron Allen, Jamestown S’Klallam Tribe; Chairman of the National Advisory Committee of Self Governance Tribes

“IF I COULD LEAVE YOU WITH ONE THING, IT’S THAT ALL THE QUESTIONS AND CONCERNS YOU HAVE IS WHERE WE WERE TWENTY YEARS AGO... AT THE TIME IT WAS A TREMENDOUS LEAP OF FAITH.”

- Valerie Davidson,
Senior Director of Legal &
Intergovernmental Affairs for
the Alaska Native Tribal Health
Consortium



Gathering Wisdom V (May 15-17, 2012)

Navigating the Currents of Change

- Panel Presentation: Success Stories

- Dan Winkelman, Vice President for Administration and General Counsel, Yukon-Kuskokwim Health Corporation.
- James Moore, Chairperson, Nisga'a Valley Health Authority



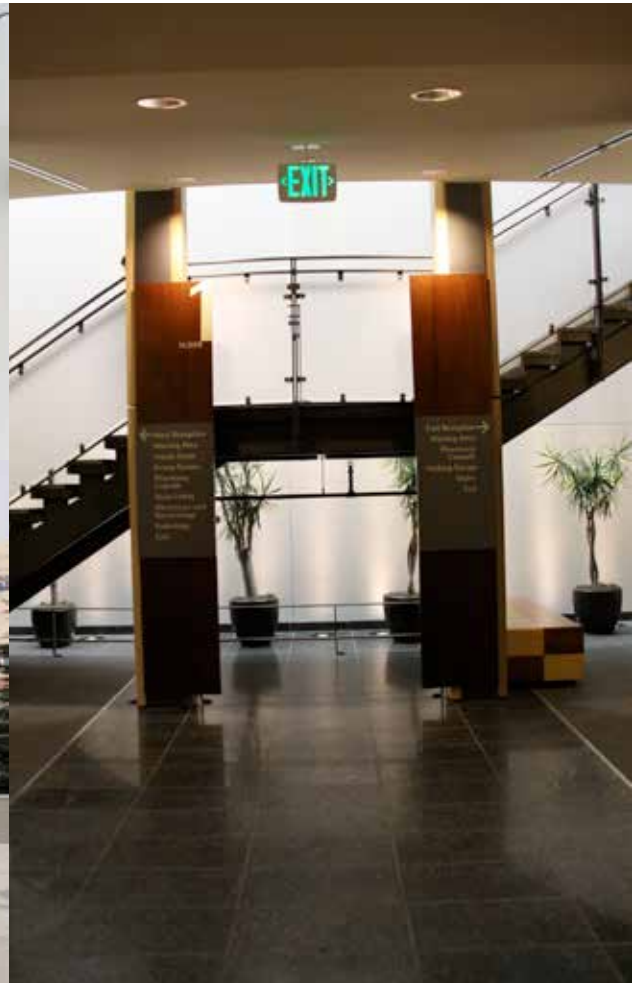
"UNITY IS POWER. IF YOU'RE NOT UNIFIED, YOU DON'T NEED AN ENEMY, LOOK ACROSS THE TABLE."

- Ron Allen, Jamestown S'Kallam Tribe.



"IT'S NOT JUST ABOUT ACCREDITATION, IT'S ABOUT QUALITY. WHEN YOU'RE RUNNING YOUR OWN PROGRAMS IT'S NOT JUST ABOUT KEEPING THE DOORS OPEN."

- Dan Winkelman,
Vice President for Administration
and General Counsel of the Yukon-
Kuskokwim Health Corporation.



In addition to having experts in international health governance with indigenous people present to the Gathering Wisdom forum, the FNHC and FNHA have sent political and technical representatives on a number of fact-finding trips.

2010 Fact-finding trip to Aotearoa (New Zealand)

Technical staff travelled to Aotearoa in 2010 to learn about the Maori experience working with the government of New Zealand. The visit included visits to four health authorities with Maori Health units, cultural competency activity, Maori-specific health services, and a meeting with government Ministers and Associate Ministers (both of whom are Maori).

2010 Tribal Self-governance Annual Conference—Phoenix Arizona.

Technical representatives of the FNHA attended the conference in May of 2010. The conference was hosted by the Self-governance Tribes, the US Department of Health & Human Services/Indian Health Service, and US Department of the Interior/Bureau of Indian Affairs. The conference featured numerous workshops and presentations regarding health governance in the US, including Alaska.

July 2011 Health Canada trip to Alaska.

In July of 2011 Health Canada sent several representatives to Alaska to investigate the health governance in the state. From this trip a report – [Alaska Native Health System Lessons Learned – July 2011](#)

was produced. Two of the Health Canada staff who witnessed Alaska have joined the FNHA on secondment and pending their permanent transfer to the FNHA. With their secondment their expertise is available to the FNHA.

August 15-17, 2011 – Political visit to Alaska.

Representatives of the FNHC travelled to Alaska to learn about the experience of Alaska Tribes in managing their own health services. The trip involved representatives from the FNHC as well as the CEO of the FNHA and some of his technical advisors. The visit was facilitated by the Alaska Native Health Board (ANHB).

Key lessons learned from Alaska

- Tribal self-governance has been very successful in producing better health outcomes.
- Tele-health has been hugely successful in improving access, quality of care and health outcomes.
- Legislation plays a key role in ensuring all parties 'hold the system together'
- Alaska has created a model similar to the BC First Nations Health governance model and has many lessons to offer as a result of more than 20 years of experience running their system.

US Models and what they have to offer

The US models, especially in the State of Alaska, provide some excellent learning for the governance work that is being undertaken by First Nations in BC. Native American and Alaska Native tribes have been in a model of 'self-governance' for more than 20 years. Some initiated self-governance in health in the mid-1990s and some were in self-governance with the Bureau of Indian Affairs (BIA) programs for at least 10 years prior to this. When the US Department of Health and Human Services branch of the Indian Health Service (IHS) decided it would devolve program oversight and delivery from IHS to tribes under their Self-Governance legislation, many tribes in the US took this opportunity. The IHS maintains a presence on a number of reservations in America but many Nations have had service delivery either partially or fully devolved to them under a systematic process of transferring health care authority.

This has been a voluntary process and no Native American tribe is forced to accept devolution. They may choose to have the IHS remain as the agency responsible for managing hospital, primary, mental health and addiction and other health care services on their behalf. For those tribes who have taken over responsibility for health services, they may be operating their own secondary care hospitals, primary care centres and public health programs for their entire populations - under a self-governance arrangement known as a 'compact' agreement or under a normal 'contract' agreement where IHS defines the programs and services that the tribe must deliver. Compact arrangements are managed by the Office of Tribal Self Governance (OTSG) based in IHS in Washington DC. The OTSG retains a 'Tribal Self-Governance Advisory Committee' (TSGAC) made up from Compact tribal representatives who lead and give advice to the IHS Director and OTSG on self-governance issues.



Interior: Alaska Native Medical Centre, Anchorage Alaska. The centre provides a warm and welcoming and culturally appropriate atmosphere for the Alaskan Natives.

The IHS also retains a group called the Office of Direct Service Tribes (ODST) and a 'Direct Service Tribes Advisory Committee' (DSTAC) for those tribes who are only contracting and/or are still receiving services directly from the IHS. IHS still employs approximately 15,000 people and continues to deliver services to tribes who have not compacted. The DSTAC ensures their interests are represented at IHS tables as well. DSTAC participates in budgets, planning and policy meetings with IHS as if they were part of the IHS, rather than simply recipients of IHS services. Under a compact, a tribe has full authority to move money between budget

lines and to re-design services and programs. Under a contract agreement, the tribe cannot move money between budget lines and they cannot re-design or re-scope services in any way.

As each tribe assumes its tribal 'share' of headquarters and the area office, IHS downsizes and re-orientes itself to managing the arrangements rather than delivering services and programs. The IHS therefore changes its role to become an advocate for tribal interests and providers of technical assistance for tribes rather than a direct provider of health services.

Lessons from the Alaska Tribal Health System

The Alaska Tribal Health System (ATHS) is the network for the entire Alaska Native health care delivery system. It is a voluntary affiliation of 40 Alaskan tribes and tribal organizations providing health services to Alaska Natives/American Indians, formerly provided by the IHS. Each tribe or tribal health organization is autonomous and serves a specific geographical area. In March 2004, members of the ATHS signed a Memorandum of Understanding setting out common goals. In total an \$800-million budget from state and federal sources, including Medicaid, Medicare and sanitation funding, supports the ATHS. The ATHS has almost full control over program delivery, policies, services and design, and controls 99% of the Alaska area budget from the IHS today. However, it must still access its federal funding through the IHS. There are still approximately 37 residual positions in the Alaska Area IHS that perform inherently federal functions and cannot currently be contracted to tribes or tribal organizations.

With all the tribes involved, the ATHS network serves approximately 130,600 Alaska Natives, a number which is projected to reach 160,000 by 2015. The ATHS delivers a range of medical care at different service levels. There are 180 small community primary care centres; 25 sub-regional mid-level centres; four multi-physician health centres; six regional hospitals, as well as the Alaska Native Medical Centre tertiary care in Anchorage. The ATHS also provides referrals to private medical providers and other states for complex care.

The ATHS is made up of 40 organizations:

- A state-wide service provider (Alaska Native Medical Centre in Anchorage) operated by the Alaska Native Tribal Health Consortium (ANTHC) and created in 1998 with congressional authorization through Section 325 of Public Law 105-83, in partnership with the South Central [tribal] Foundation
- Regional Service Providers/Corporations/Consortia who operate regional hospitals, physician centres and sub-regional centres such as South Central Foundation, Norton Sound Health Corporation and Cooper River Native Association
- Individual village health centres

The size, diversity and number of First Nations communities in Alaska are similar to those in BC and also face the realities of rural settings, remoteness and isolation. BC First Nations leaders are well aware of the lessons that can be taken from the Alaska model and applied to the BC process.

Lessons from New Zealand Maori Treaty partnership with the Crown

The New Zealand Maori tribes' Treaty of Waitangi partnership with the Crown also provides some useful lessons about working with the Crown and influencing all levels of government, from ministers through to ministries and health authorities. Maori tribal participation in the health sector has been growing exponentially since 1990 after major health reform, and they too have some lessons to offer about health system transformation, particularly with large health authorities. Tribal leaders' engagement with principals in their system offer some valuable lessons for First Nations leaders in BC and the FNHA continues to gather evidence which can contribute to this learning. There are approximately 190 Maori/tribal service providers. These groups developed innovative models of health care delivery that offer useful knowledge and experience to BC First Nations service providers. The Maori experience of transformative change within their District Health Boards is also important and can be shared with BC's health authorities.

The Maori health sector also benefits from considerable Maori research expertise, led by academic and independent Maori research entities. As well, Maori have been remarkably successful in growing their own health workforce. Data from the New Zealand workforce census showed that there were more than 3,000 Maori health professionals in the workforce, including more than 2,000 nurses; 200 medical practitioners, 500 social workers, 200 psychologists, 40 dentists and pharmacists and 10 surgeons. Given these numbers, the workforce development strategies of New Zealand can provide important insight to BC First Nations and others in developing their own First Nations health workforce.



A major key to success has been the generosity of international



...al indigenous partners. A fact finding trip to New Zealand in 2010 to investigate the Maori system of care.



7) Growth: Acknowledging the



Throughout this journey of health systems transformation in BC, there have been – and continue to be – challenges along the way. Some of these challenges have been overcome, while others persist. Fortunately, we have learned a great deal along the way. The key themes described in “Our Story” – Leadership, Governance, Partnership, Community Engagement, and Learning – provide us with the tools to continue to address the challenges as they arise.

Little Precedent for the Work

It was unprecedented to undertake such an ambitious and far-reaching set of health reforms requiring this level of cooperation between partners and the meaningful participation of BC First Nations. No other province in Canada had signed a health agreement between First Nations and the federal and provincial governments for the kind of change anticipated under the BC agreements. No other First Nations organization had undertaken

The small FNHA team faced a major challenge: to influence large, complex systems and create space for First Nations to sit at the table with decision-makers and make sustainable changes for the benefit of First Nations people.

Diverse and Unequal Structures between the Partners

The FNHA structured its organization to reflect the key objectives of the TCA: FNHP and later the TFNHP. Provincial and federal partner structures, as large bureaucracies that had been in place for some time, were not equally positioned to begin implementation of the Health Plans set forward.

There was no previous model for how government structures should be organized to participate in these types of health partnerships. In 2008 the BC Ministry of Health restructured and split into two ministries – the Ministry of Healthy Living and Sport and the Ministry of Health Services. In 2010 they restructured again to bring the two ministries back

e Challenges

en such a massive responsibility, tasked with influencing change in an industry worth over \$15.4 billion annually¹ with over 100,000 personnel in multiple institutions and agencies. The provincial health ministry and the regional health authorities are large multi-layered organizations with executives and managers at many levels.

together. As a result of these changes there was little consistency in provincial leadership and civil servants and the FNHA spent a great deal of time bringing provincial leadership and civil servants up to speed.

Since the size, scope and jurisdictions of the partner organizations were vastly different, there were no obvious 'equals' among the partners to work together in a collaborative fashion. Vice-presidents in one partner organization would have to work with Executive Directors in another. Assistant Deputy Ministers in the provincial system had to engage with regional directors in the federal system. First Nations senior leadership had to find a way of balancing engagement at the right levels, with both partners. The different mandates of the two government partners only added to the challenges. The federal system focuses on First Nations on on-reserve, while the provincial system has a broad 'Aboriginal' health mandate.

At the outset, an additional complexity was that the government personnel assigned to partner with the CEO of the FNHA had little or no authority to actually make decisions or changes within their respective systems. At the provincial level, the Aboriginal health branch was assigned responsibility for TFNHP implementation. At the time the Aboriginal health branch did not have the authority over the aspects of the health system that most needed changing.

Much of the on-the-ground changes could only come from within the regional health authorities, and there was a need to engage with the CEOs of the regional health authorities. In early days of health plan implementation, most health authorities designated their Aboriginal health teams and Aboriginal health leads to provide leadership in implementing the health plan. Again, these teams and personnel lacked the required authority to initiate the transformative change called for in the TFNHP.

Similarly, Health Canada appointed a very small team without appropriate authority to make the

types of changes called for by the TFNHP. This challenge was further heightened by the relationship between headquarters and the regional office. The current structure puts a great deal of accountability on the region, while leaving decision-making responsibilities with headquarters. Determining when to engage with headquarters personnel (who often had decision-making power); versus regional personnel (future FNHA employees with local knowledge) was a learning experience for senior staff of the FNHA.

The challenge for participants and decision-makers operating at different levels in the partner organizations including First Nations continues to be a reality. Ongoing investment in relationship-building and partnership helps to improve the process of working together year by year.

Cultural Differences

The FNHA also faced large governments with staff who were unfamiliar and unprepared for the close working relationship between Canada, BC and First Nations communities that was required in the new Tripartite Agreement. There had been previous initiatives² that required engagement with First Nations but nothing as extensive as was envisioned under the Health Plans.

Much of the Health Plan work was a new journey for all of the partners, including First Nations communities and the FNHA staff. Without a history of working in a tripartite way, there was a significant need for education and awareness for all parties. Partner governments needed to understand the implications and intentions of the health plans, and how to work effectively with First Nations communities.

First Nations needed to learn how to engage with governments in a constructive way, given the his-



One of the concerns widely expressed by First Nations was fear of off-loading or a 'dump and run' by the federal government in the transfer of services from Health Canada.

torical issues preceding and affecting this type of new relationship. The ongoing need for greater understanding, appreciation and context for all partners continues to be a key concern for the FNHA. The responsibility of senior executives in each of the partner organizations to educate and raise awareness among their own large networks and staff about the Health Plans and the goals of a tripartite relationship is an ongoing challenge.

First Nations organizations operate in ways that are unfamiliar to other governmental and health authorities. For instance, the development of a negotiations mandate took years, not months as intended. The need to check in with First Nations leadership and technicians every step of the way was new for government.

Concerns with Off-loading and Fiduciary Duty

One of the concerns widely expressed by First Nations was fear of off-loading or a 'dump and run' by the federal government in the transfer of services from Health Canada. The devolution process that the Department of Indian Affairs³ engaged in throughout the 1980s featured changes of authority and downsizing regional offices that were widely viewed as already under-resourced. In this process, many responsibilities were transferred to First Nations without adequate funding to take on all of the responsibilities. First Nations leaders had no interest in a repeat of off-loading in health. Further, many First Nations were concerned that the proposed changes to health services administration could detract from the fiduciary duty owed to First Nations by the federal government. The uncertainty was is

some ways magnified by the fact that a large majority of First Nations have not signed treaties. Essentially, there was limited appetite for pursuing health reform on a rights-based approach or in any manner that would impact upon the Crown's duties to First Nations.

The Parties worked together to address these concerns. It was very clearly communicated that the health reform process is an administrative transfer of responsibility, as opposed to a rights-based approach. It was determined that the administrative transfer could improve the health outcomes of First Nations people while avoiding messy debates that would be unlikely to gain either consensus among First Nations nor support from government partners. The administrative transfer approach has no impact on the fiduciary duty owed by Canada to First Nations, and this point was very clearly captured in the legally-binding Framework Agreement. This approach played an important part in gaining further support from Chiefs⁴.

A 10-year plan with no funding certainty

When the TCA: FNHP was signed, there was a political understanding between the Province of BC and the FNLC that it would cost \$24M to implement the 29 action items. This included \$4M which the Province would re-allocate internally; \$10M in new money that the Province would commit to fund the plan; and \$10M in new money that the parties expected the federal government to bring to the table to implement the plan.

When Health Canada signed on to the TFNHP, there was no clear agreement that they would annually provide their \$10M in new money to

specifically implement the 29 action items. They also brought forward additional priorities, such as the commitment to design and implement a new structure to govern First Nations health services in BC. Resources were needed to support First Nations involvement in the implementation of the health plan. Resources were also required to cover the cost of establishing and running the FNHC and any subcommittees. By the end of 2007-2008, the FNHC had secured a four-year funding agreement from the federal government but nothing from the provincial government. Instead, the Province advanced annual grants of various sums in years one and two.

In 2010, the Province initially did not provide any funding but then agreed to *'restart the clock'* on the TFNHP and to fund the plan for a renewed 10-year period. This was significant in bumping the measurable timelines back three years in an acknowledgment of the unrealistic timeframe. It was also clear in the initial phases that the FNHC and government partners had different expectations about the funding. The government partners had an expectation that they would have a role in deciding how it was spent. The FNHC had the view that the funding was for investing in the capacity of First Nations to support and participate in the TFNHP, and to minimize risk by ensuring there were reserves for ongoing years.

The FNHC was therefore faced with the position of having a signed 10-year agreement without any funding security from the partner governments for the 10-year period. This challenge has affected the FNHC's ability to make strategic investments in the implementation of the plan, or to assure BC First

Nations communities that they will be resourced effectively to participate in the plan over the 10-year period. Securing funding certainty has been a key priority.

Ultimately, following other written and verbal commitments, the Framework Agreement firmly established the ongoing funding support from the provincial and federal governments for Health Plan implementation, and for the design and delivery of health programs and services to First Nations in BC. During negotiations of the Framework Agreement, economic woes in the global economy and the associated impact on government revenues, coupled with drastic tax cutting at both the federal and provincial levels, created an environment where both levels of government were in

cost-cutting mode. All of which served to increase First Nations concerns. Negotiators of the Basis Agreement and Framework Agreement worked to ensure that existing funding was protected and that the new governance structure would be flexible enough to enable the FNHA to raise revenues. Through discussions with other Indigenous people worldwide who had undertaken their own health reform process, the FNHA learned that the ability to raise revenue was an important piece of the puzzle. The Framework Agreement protects existing funding and includes a modest escalator clause whereby the funding increases every year. The retention of several programs considered *'sun-setting'*, such as the Aboriginal Diabetes Initiative were also achieved through negotiations.



8) Taking Control: The Road to

"WE KNOW WHAT IS WRONG, OUR JOB NOW IS TO PUT IT RIGHT.

AND WHEN WE WALK THROUGH THAT DOOR, WE CAN'T GO AS ONE... ONE COMMUNITY, ONE NATION, ONE REGION, ONE PART OF BC AND NOT THE REST. WE HAVE TO WALK THROUGH THAT DOOR TOGETHER."

- Kukpi7 Wayne Christian , Splatsin.

Transferring FNIHB BC Region to the FNHA

The transfer of FNIH operations in Health Canada's BC Region to a FNHA is a first for Canada and will enable First Nations to have more control over decisions relating to their health. A key milestone was the signing of the Framework Agreement in October 2011, but that only signaled the start of a much more complex phase of the journey.

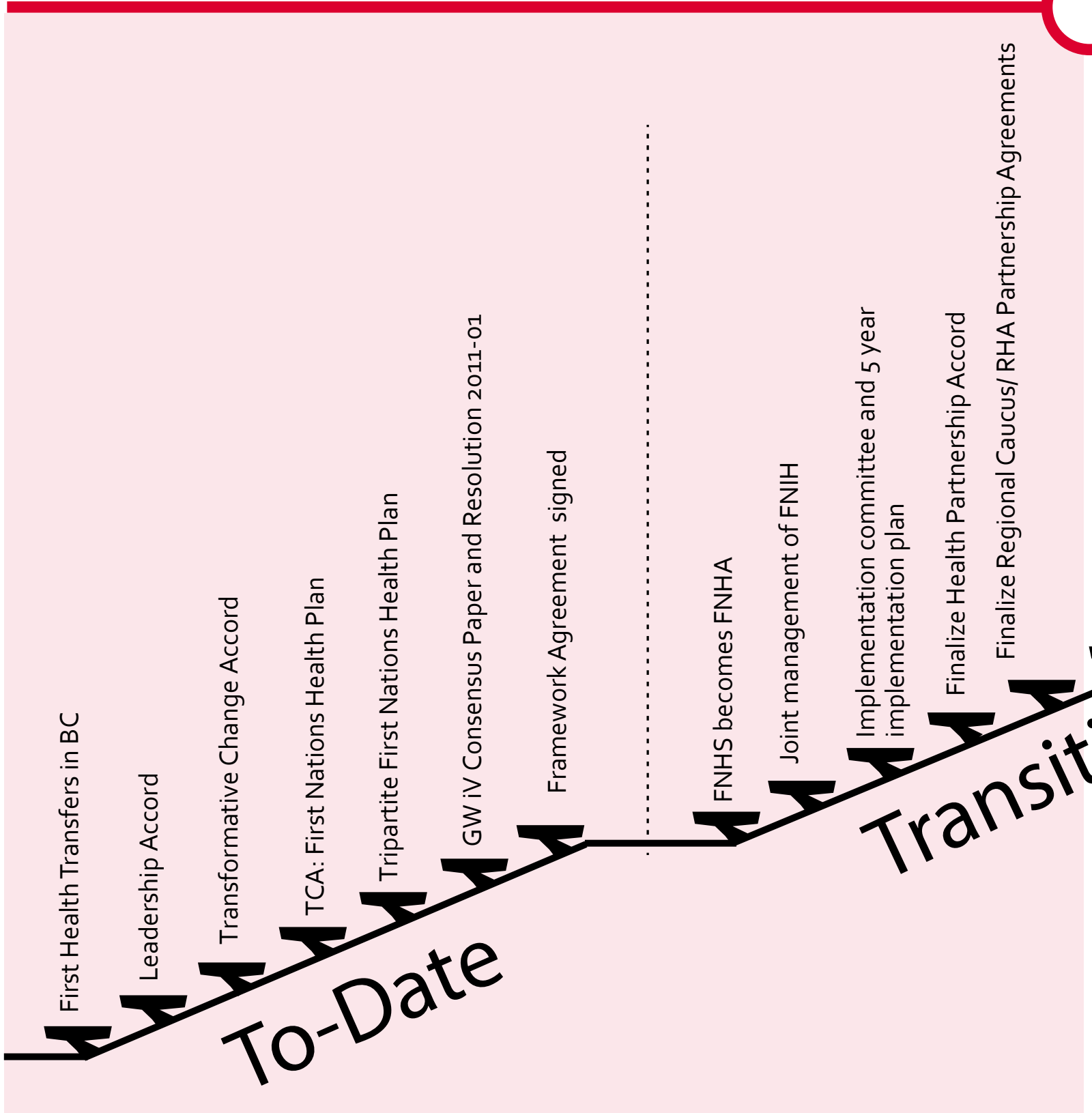
The Framework Agreement requires the transfer to take place within a two-year timeframe – by October 2013. To make this happen, the Parties must complete a series of sub-agreements to describe the logistics and legalities of transferring the people, assets, facilities, funding, and other functions that support the FNIHB-BC regional operations to the FNHA. The FNHA must also ready itself to receive the transfer.

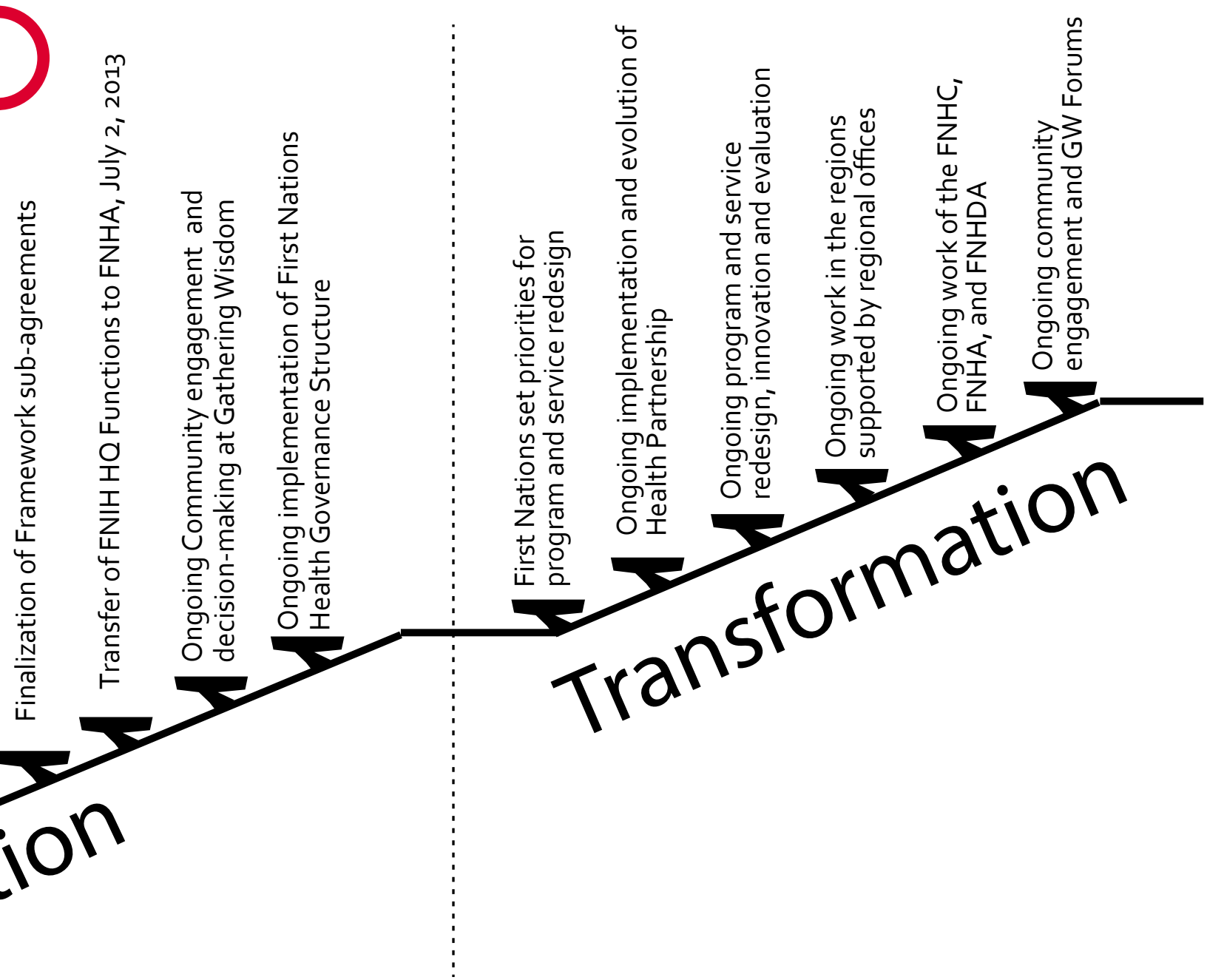
The complexity of the transfer process cannot be overstated. To ensure that the process does not go off-track or get bogged down by the interests of any one party, the Parties have agreed to a set of guiding success factors to inform decision-making with respect to the transfer:

- Ensuring **no disruption and minimal adjustment** required by individual First Nations people and communities to the continuation of their health services or health benefits.
- Ensuring **minimal disruption and minimal added work burden** on First Nations program providers who deliver community programs.
- Respecting the **7 directives**.
- Respecting the **vision and principles of the Framework Agreement** and create a solid foundation for its continuing implementation.

Transformation

We are here





Transformation timeline- Staging the work has been helpful in navigating the complex change mandated through the health reform process.

Four main elements of the Transfer process

- 1 • **Building solid systems and structures** – In preparation for the transfer the FNHA must put in place solid systems for Information Management, Finance, Human Resources, Health Benefits and others. Some FNIHB systems are transferable, while others will need to be developed. Health Canada has agreed to develop a Business Continuity Plan with the FNHA to assist in a smooth transfer of responsibilities.
- 2 • **Assuming the assets** – At the time of transfer, the FNHA will take over a number of assets that currently belong to Health Canada. These include vehicles, medical equipment, office furniture & equipment, computer hardware and other assets. Financial and Human Resources are also part of the transfer. More than 220 Health Canada employees will be offered employment with the FNHA. This involves substantial preparation in policies, and addressing issues with unions. The FNHA will also assume an annual budget that is considerably larger than what it works with today. To prepare for this a number of sophisticated systems, controls and governance are being developed to ensure this responsibility can be met at a high standard.
- 3 • **Taking over programs & services** – The FNHA will assume responsibility for all programs and services run by the BC Region of FNIHB. During the time of transfer and for much of the transition stage these programs and services will remain largely unchanged. Minor alterations may be possible to correct obvious shortcomings. The FNHA will undertake engagement with First Nations to fine-tune and in some cases redesign current programs and services.
- 4 • **Creating a new shared organizational culture** – Creating a health organization that reflects First Nations values and philosophy is an ongoing process. There will be much work to establish the FNHA as a champion of health and wellness. The successful merging of federal public servants into the FNHA, which has such a different history and culture, will be a significant undertaking to enable a successful transfer.

Once negotiations on sub-agreements have been completed, the FNHC and the FNHA Board of Directors will review them to ensure that “the ‘package of agreements’ are collectively and individually workable and provide the FNHA what it needs to be a sustainable and productive health organization for BC First Nations.”⁵

The transfer of resources will take place in phases, starting in July 2013 and ending in October 2013. This approach aims to support a smooth transfer of responsibilities and avoid disruptions to First Nations clients and Health Canada staff affected by the upcoming changes.



Better Together meeting- December 12, 2012 the First Nations Health Authority hosted a joint all staff meeting with current Health Canada employees slated for transfer. Getting to know one another and establishing a joint organizational culture are important aspects of change management.

THE ROAD TO TRANSFORMATION

The purpose of this health systems transformation journey is to achieve the vision of “Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities” – through greater First Nations control and decision-making over the design and delivery of health systems, programs, and services, to turn the existing “sickness system” into a “wellness system”. Transformation of the existing system to one that is wellness-based is a change management process that will take many years, and be grounded in the lessons outlined in Our Story. A number of things are being done differently now, and will lay the groundwork for long-term health systems reform.

Addressing Immediate Health Needs

First Nations communities are chronically underfunded, and are often unable to secure funds for innovations or crisis situations. The FNHA knew that First Nations could not focus on long-term systems transformation and Health Plan implementation if they were dealing with immediate crises.

The FNHA had funding available for ensuring First Nation participation in the Health Plans and to support communities moving forward in their health initiatives. One purpose of the funding was to meet the immediate needs by bringing worthwhile initiatives, innovations and leaders to the forefront. This way, space was created for these models and experiences to expand and develop. Funding of these kinds of projects in communities was in no way an attempt to displace federal and provincial responsibilities for services. Rather, it was an initial strategy to draw out positive models and experiences that could contribute to the implementation of the plans. First Nations community initiatives, innovations and success stories contribute to build-

ing a strong dialogue between all partners, BC First Nations and observers to understand and identify models of best practices.

Funding was also provided in a number of crisis situations. Funding for crisis situations, which included events like youth suicides, was aimed at supporting communities by resourcing organizations like the Aboriginal Suicide and Critical Incident Response Teams in various areas of the province. This engagement with First Nations in crisis underlined that before communities could become engaged in the TFNHP from a strategic long-term perspective, first they needed help to come together to support one another in times of crisis.

In addition to addressing the immediate concerns of communities, support for collaboration through the hubs was a vital step to encouraging peer support and a feeling of connectedness. The FNHA’s role in helping to overcome these immediate concerns, and in building relationships between communities, has meant BC First Nations are now much better positioned to engage in looking forward as the TFNHP continues to be implemented.

Social Determinants of Health

A strong belief amongst BC First Nations is that health is an outcome – it is an outcome of many other social and economic circumstances facing First Nations communities. Without addressing these other circumstances, health outcomes are unlikely to improve. This is a holistic way of looking at wellness, and a cornerstone of First Nations traditional and contemporary worldview.

All societies are affected by social and economic factors in complex and inter-related ways. These factors affect health and wellness, determining in



part whether people remain healthy or become sick, and determine resilience when people are unwell. These socio-economic factors are called 'social determinants of health' by policy makers and health care professionals.

Under the Framework Agreement, both BC and Canada agreed to make arrangements for the FNHC to meet with Deputy Ministers to discuss issues related to health that fall outside the strict parameters of health service delivery. This level of engagement will allow First Nations to address broader issues related to the social determinants of health. Addressing social determinants of health is a key part of health system transformation. Up until now First Nations have not had an effective way of advancing a comprehensive social determinants agenda with government. The opportunity to address these social determinants is vital to improving the health outcomes and lives of First Nations, in partnership.

Social determinants of health can be understood as the social and economic conditions in which people live and which influence the health of the individual and their community. They include:

- Social Status & income
- Education
- Employment & working conditions
- Food security
- Gender
- Health care services
- Housing
- Social exclusion
- Social Support Networks
- Early (Childhood) Life

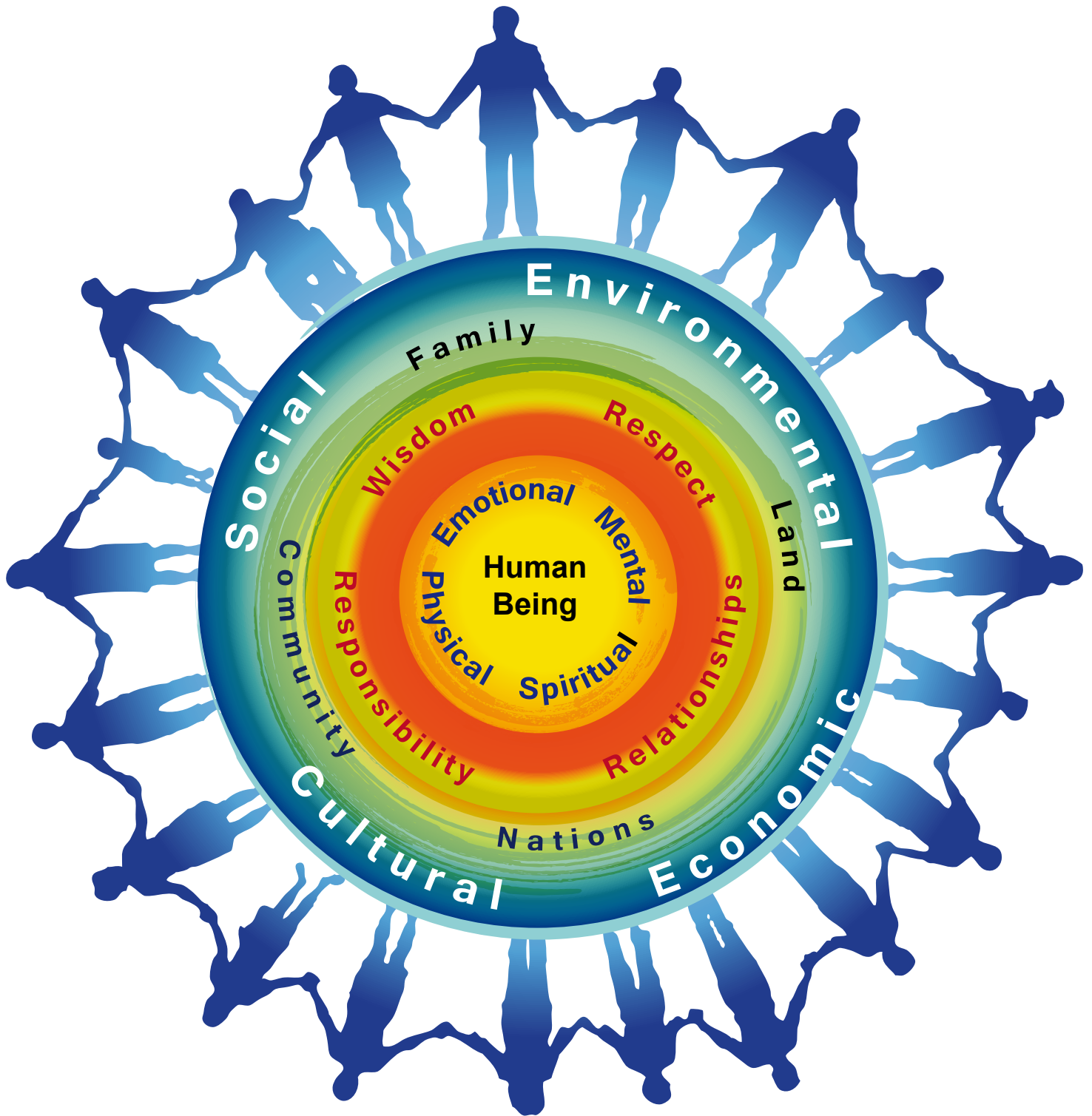


Approach to Health and Wellness

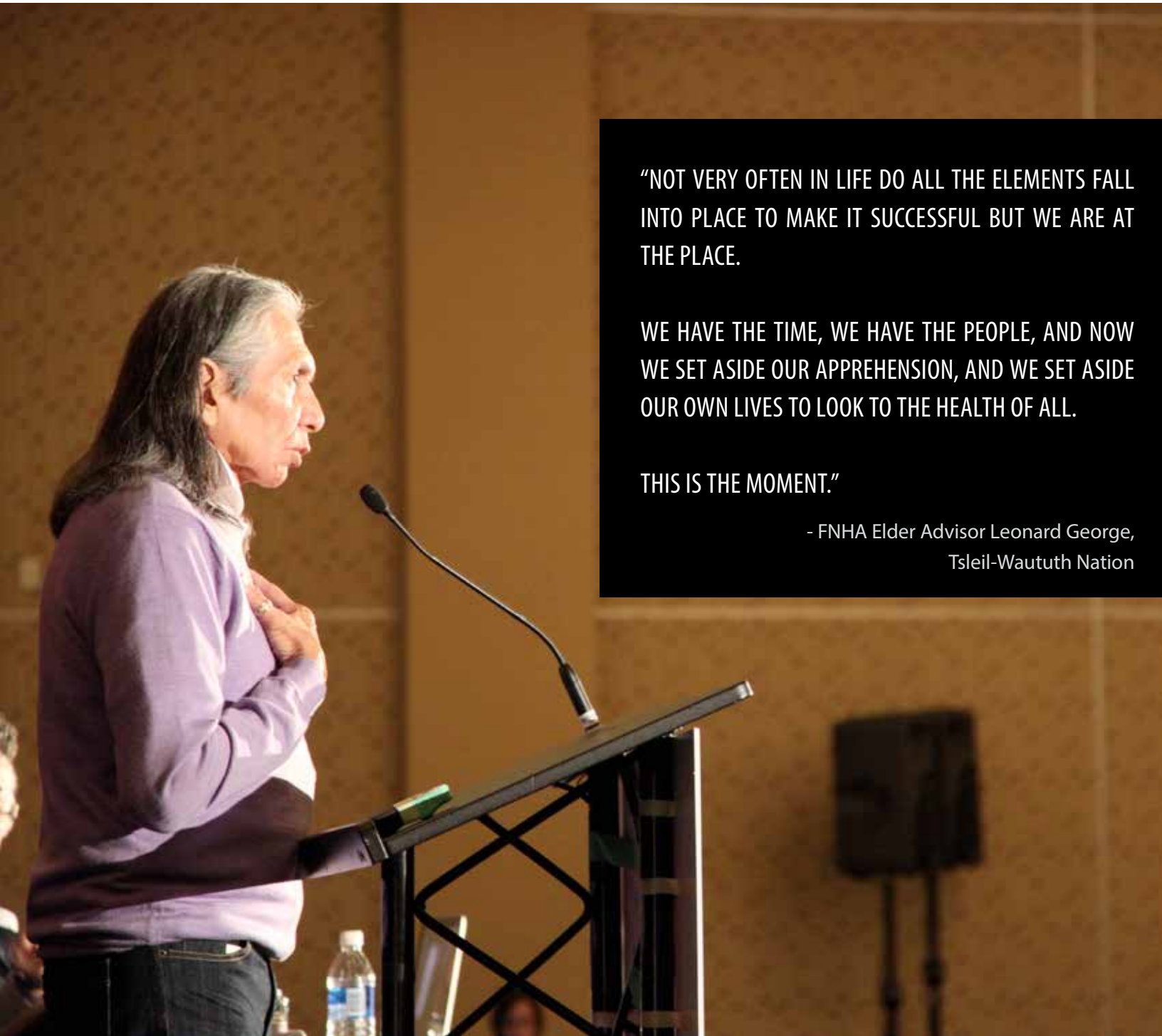
The approach to health systems transformation in BC is “health through wellness”. The FNHA will serve as a health and wellness partner to First Nations. At Gathering Wisdom for a Shared Journey V in May 2012, First Nations reviewed and provided feedback to a Wellness Model. The Model describes a uniquely First Nations philosophy of health and wellness. This philosophy, at the highest level, guides the ongoing development of the First Nations health governance structure, and the functions and activities of the First Nations health governance structure.

The core components of the Wellness Model are: Nurturing Spirit; Respecting Tobacco; Being Ac-

tive; Eating Healthy; and, Maintaining Healthy Body Weight. The FNHA will provide strategic-level education, tools and initiatives in support of the Wellness Model, supported by initiatives such as evaluation and accountability mechanisms (like health screenings), and an extensive communications program. The FNHA will also serve as a wellness partner to First Nations by supporting groups and individuals to live the Wellness Model in their daily lives, such as through the development and implementation of policy and other organizational initiatives, and the roll-out of personal health and wellness planning templates and tools. The Wellness Model meets groups and individuals where they are at, and helps them to focus on health and wellness priorities that they have at any given time.



BC First Nations Perspective on Wellness Model



“NOT VERY OFTEN IN LIFE DO ALL THE ELEMENTS FALL INTO PLACE TO MAKE IT SUCCESSFUL BUT WE ARE AT THE PLACE.

WE HAVE THE TIME, WE HAVE THE PEOPLE, AND NOW WE SET ASIDE OUR APPREHENSION, AND WE SET ASIDE OUR OWN LIVES TO LOOK TO THE HEALTH OF ALL.

THIS IS THE MOMENT.”

- FNHA Elder Advisor Leonard George,
Tsleil-Waututh Nation

Conclusion

Making changes on a province-wide scale to a complex system such as health care has been a monumental undertaking. This work is been unprecedented in Canada – the path forward on this journey was largely unmapped.

One of the first steps to success was the drive by BC First Nations to take control over their health needs and work together with ‘one heart and one mind’ focused on a long-term agenda. Through this unity, First Nations were able to generate the political will of provincial and federal governments to undertake such ambitious changes. This political will on both sides provided the foundation for ongoing partnership development – over a period of nearly a decade the relationships between both levels of government and First Nations in BC have dramatically changed with regard to health. Over time, the partners have become more accountable, accommodating and responsive to one another for the successful implementation of their shared commitments. Each partner has made changes to be a better participant in the partnership and has made investments to demonstrate their commitment to the health transformation process.

Early, ongoing, and meaningful involvement of First Nations continues to drive the process. It was crucial to gaining support and trust for such a major undertaking, and ensured that issues and concerns were aired and addressed. By providing ample opportunity through a robust community engagement process for First Nations to collectively direct health systems transformation, BC

First Nations have created our First Nations health governance structure, and will design health systems, programs, and services to meet our needs.

We have learned much from Indigenous allies worldwide. These have helped guide our journey, and have provided the inspiration to continue on our path. We are committed to an ongoing learning process, and to sharing our lessons with others that may be interested in a similar approach.

There is an opportunity at hand to design a system that is effective, innovative and built from the ground up, based on the needs of First Nations communities. This work is already underway through the partnerships between First Nations and Regional Health Authorities. After the transfer of FNIHB-BC Region to the FNHA, First Nations will undertake the redesign of programs and services that reflect BC First Nations values. A new wellness-based health care system for BC First Nations that integrates the best of traditional and contemporary medicine brings the concept of healthy communities full circle and will define health in a meaningful way for BC First Nations communities. The new health governance approach for BC First Nations is only the beginning of transformative changes that are on the way in all other areas related to the social determinants of health.

There is still much work ahead, but the work to date in designing a functional and effective First Nations health governance structure offers promise that will change the lives of all BC First Nations and leave a lasting legacy in the province of BC and across this country. This shared journey is transforming and lending innovative teachings for the benefit of the broader health systems in Canada and BC.

Endnotes- Chapter 1

- 1 Health Canada (2011). Canada's Health Care System. Retrieved February 15, 2013 from <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php#a3>
- 2 Kelly, Miranda D. (2011). Toward a New Era of Policy: Health Care Service Delivery to First Nations. *The International Indigenous Policy Journal*, 2 (1),4.
- 3 Canada Health Act (R.S.C., 1985, c. C-6).
- 4 Lavoie, Josee G. (2004). Governed by Contracts: the Development of Indigenous Primary Health Services in Canada, Australia and New Zealand. *Journal of Aboriginal Health*, 11. [As cited by FNHC, 2009. Models of Health Governance in Canada, the United States, New Zealand, and Australia. Unpublished].
- 5 Health Canada (2012). Canada Health Act Annual Report 2011-2012, chapter 1. Retrieved February 15, 2013 from <http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2012-cha-lcs-ar-ra/index-eng.php#a3>
- 6 Health Canada. (2010) Canada's Health Care System (Medicare). Retrieved March 2, 2012 from: <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php>
- 7 Health Canada First Nations and Inuit Health. The First Nations and Inuit Health Branch Strategic Plan: A Shared Path to Improved Health (2012). Retrieved February 18, 2013 from <http://www.hc-sc.gc.ca/fniah-spnia/pubs/strat-plan-2012/index-eng.php>.
- 8 National Collaborating Centre for Aboriginal Health (2011), The Aboriginal Health Legislation and Policy Framework in Canada. Retrieved from http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/2/Health%20Legislation%20and%20Policy_English.pdf
- 9 BCAFN. Building on Our Success – Governance Toolkit. S.3.15 Health. Retrieved February 18, 2013 from <http://www.bcafn.ca/toolkit/governance-bcafn-governance-tool-3.15.php>
- 10 Health Canada – FNIHB Website. Retrieved February 18, 2013 from <http://www.hc-sc.gc.ca/ahc-asc/branch-dir-gen/fnihb-dgspni/sppad-dppas/index-eng.php>
- 11 Ibid.
- 12 In Canada First Nations people living on Indian Reserves are subject to different government and services than for those living elsewhere. The term used for those residing on Indian Reserves is "On-reserve" and for all others – those residing in urban areas and other locations that are not part of the Indian Reserve are deemed as living "off-reserve" in general parlance.
- 13 BC First Nations Tripartite Agreement on First Nation Health Governance. Retrieved June 15, 2012 from <http://www.fnhc.ca/pdf/framework-accord-cadre-eng1.pdf>
- 14 Retrieved February 18, 2013 from <http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/bull/2003-5-aboriginal-autoch-tone/index-eng.php>
- 15 Ibid.
- 16 Health Canada – Non-Insured Health Benefits Program Website. Retrieved February 18, 2013 from <http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/yhb-vss/index-eng.php>
- 17 Yousuf Ali, Regional Director BC FNIHB.
- 18 Lavoie, J.G., Forget, E. L., & Browne, A. J. (2010). Caught at the crossroad: First Nations, health care, and the legacy of the Indian Act, *Pimatisiwin: A Journal of Aboriginal and Indigenous Community health*, 8(1), 83-100, and Kelly, Miranda D. (2011). Toward a New Era of Policy: Health Care Service Delivery to First Nations. *The International Indigenous Policy Journal*, 2 (1),4.
- 19 Ibid.
- 20 First Nations Leadership Council (2004). First Nations Health Blueprint for British Columbia. Submitted to the Assembly of First Nations by the BC First Nations Leadership Council. July 15, 2005.
- 21 The Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11
- 22 Canada Health Act (R.S.C., 1985, c. C-6)
- 23 BC Ministry of Health (2012). 2012/13 – 2014/15 Service Plan. Retrieved February 18, 2013 from <http://www.bc-budget.gov.bc.ca/2012/sp/pdf/ministry/hlth.pdf>
- 24 Ibid.
- 25 Supra at Note xxi.

- 26 Supra at Note xxi.
- 27 Madore, O. (2005). The Canada Health Act: Overview and Options. Parliamentary Information and Research Service. Library of Parliament, Ottawa. Retrieved November 12, 2012 from <http://www.parl.gc.ca/Content/LOP/ResearchPublications/944-e.htm>.
- 28 Supra at note xxi.
- 29 Supra at note xxi.
- 30 Supra at note xxi.
- 31 Ministry of Health. (2012). About BC's Health Authorities. Retrieved December 13, 2012 from <http://www.health.gov.bc.ca/socsec/about.html>.
- 32 Provincial Health Services Authority. (2012). Specialized Health Care Services. Retrieved December 13, 2012 from <http://www.phsa.ca/default.htm>.

Endnotes- Chapter 2

- 1 For example, Treaty 8 Nations in Northeast BC, and the Douglas Treaties on Vancouver Island.
- 2 Signed by the Minister of Indian Affairs and Northern Development and the Assembly of First Nations (May 31, 2005),
- 3 Aboriginal Organizations involved included: The Assembly of First Nations, Inuit Tapiriit Kanatami, the Metis National Council, the Native Women's Association of Canada, and the Congress of Aboriginal Peoples – Aboriginal Roundtable to Kelowna Accord: Aboriginal Policy Negotiations, 2004-2005. Lisa L. Patterson. Political and Social Affairs Division. Library of Parliament. 2006.
- 4 Patterson, L.L. 2006. Aboriginal Roundtable to Kelowna Accord: Aboriginal Policy Negotiations, 2004-2005. Library of Parliament. May 4, 2006. Retrieved August 9, 2012 from <http://www.parl.gc.ca/Content/LOP/researchpublications/prb0604-e.htm> .
- 5 Patterson, L.L. 2006. Aboriginal Roundtable to Kelowna Accord: Aboriginal Policy Negotiations, 2004-2005. Library of Parliament. May 4, 2006. Retrieved August 9, 2012 from <http://www.parl.gc.ca/Content/LOP/researchpublications/prb0604-e.htm> .

- 6 Health Canada (2011) British Columbia Tripartite Framework Agreement on First Nation Health Governance. Retrieved April 2, 2012 from <http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/tripartite/framework-accord-cadre-eng.php>
- 7 First Nations Health Council (2012) Tripartite Partners Initial Basis for a Framework Agreement. Retrieved April 2, 2012 from: http://www.fnhc.ca/index.php/news/article/tripartite_partners_initial_basis_for_a_framework_agreement/

Endnotes- Chapter 3

- 1 May 20-21, 2008
- 2 At the time all funding related to the FNLC was funneled through the FNS for administration. At the time, prior to the development of the FNHS the choices were one of the three First Nations Organizations that comprised the FNLC. Harmony Johnson – pers. com. with Philip Hogan – October 25, 2012.
- 3 File No S-54796
- 4 May 24-26, 2011
- 5 Models examined included: non-profit society; a corporate model, a hybrid model or a legislated model.
- 6 First Nations Health Council (2011). Transformative Change Accord: First Nations Health Plan. Retrieved September 14, 2012 from http://www.fnhc.ca/pdf/TCA_FNHP.pdf
- 7 First Nations Health Council: 3 Years of Progress 2007-2010. First Nations Health Council. P. 78.
- 8 First Nations Health Council: 3 Years of Progress 2007-2010. First Nations Health Council. P. 35.

Endnotes- Chapter 4

- 1 http://www.fnhc.ca/pdf/Consensus_Paper-BC_First_Nations_perspectives_on_a_new_Health_Governance_Arrangement-FIN.pdf

Endnotes- Chapter 5

- 1 First Nations Health Council: 3 Years of Progress 2007-2010. First Nations Health Council. P. 25.

Endnotes- Chapter 7

- 1 2010- 2011 Service Plan MHS.
- 2 One example was 2001 Provincial Health Officer's Report, Medical Services Plan and Non-Insured Health Benefits issues.
- 3 Also known as Indian and Northern Affairs and Northern Development – now called Aboriginal Affairs and Northern Development Canada.
- 4 By Davis LLP and Maria Morellatto, Mandell Pinder LLP.
- 5 FNHA Transition Update. October 2012



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