Assembly of First Nations BC Region

First Nations Summit

Union of British Columbia Indian Chiefs

FIRST NATIONS HEALTH BLUEPRINT FOR BRITISH COLUMBIA

Respectfully Submitted to the Assembly of First Nations
By the BC First Nations Leadership Council

July 15, 2005

Purpose

The British Columbia First Nations Health Blueprint is a strategic tool to guide the ongoing development of the First Nations health sector. It is expected the document will provide the basis for a renewed dialogue with Canada and British Columbia, which will seek to increase the lifespan and improve the quality of life for our people, families and communities. The Blueprint charts a path towards the reduction of disparities with other Canadians, through defining and strengthening the First Nations health sector and the concepts of self-determination, partnership, and cultural values and practices.

Format and Focus

The Blueprint has been prepared in accordance with the *Template for Submissions* established by the Federal/Provincial/Territorial/Aboriginal Planning Group in February 2005. For the most part, the categories of information set out in the *Template* have been used in the preparation of this Blueprint. In following this format, the document necessarily focuses on the policies, systems, relationships and infrastructure that make up the health system that serves First Nations.

Limitations

The Blueprint is a work-in-progress. It was prepared within a short time frame without the benefit of direct participation by many experienced and knowledgeable First Nations leaders, Elders, health workers, advisors, and the users of the services provided through the First Nations health system. Every attempt has been made to ensure that the values, principles and directions of BC First Nations are reflected in this document. A Forum for representatives of British Columbia's First Nations provided detailed input[1] into this Blueprint on June 22, 2005.

[1] *British Columbia First Nations Health Blueprint Forum, Summary of Proceedings*, June 22, 2005, attached as Appendix "A".

Planning Context

The Blueprint has been prepared with recognition of the following relationships which form the context for its development and are essential to its implementation:

1. The Leadership Council of British Columbia First Nations is mandated through an Accord[2] between the British Columbia Assembly of First Nations (BCAFN), Union of British Columbia Indian Chiefs (UBCIC) and British Columbia First Nations Summit (FNS).
2. The Leadership Council and British Columbia have agreed to "a new government–to-government relationship based on respect, recognition and accommodation of aboriginal title and rights"[3].
3. The Assembly of First Nations (AFN) has entered into an Accord[4] with Canada in which the parties are committed to consider new policy, institutional and legislative initiatives.
4. Working relationships have been established between the First Nations leadership in British Columbia and the BC Dental Association, the BC Pharmacists Association, BC Psychological Association, Registered Nurses Association of BC and the BC Medical Association.

Vision

It is the vision of British Columbia's First Nations that our people will be served by our own *distinct* yet *interdependent* health system, which ensures a full continuum of care for our people and their families and:

1. Is founded on the holistic principles of our cultures and traditions and respects the integrity of our healing practices;
2. Respects the rights of our people and our families to realize our full potential for healthy lives on our own lands or, wherever we may chose to live;
3. Supports a quality of living that includes the right to clean air, clean water and food and healthy children;
4. Facilitates shifts in the current health system from disease models of care to First Nations community development and wellness models;
5. Recognizes the value of an empowered First Nations population that assumes responsibility for its own individual and collective well being;
6. Establishes responsive First Nations health organizations, agencies and institutions that train, employ and promote our own people in the pursuit of community-defined goals and, are accountable to First Nations; and,
7. Commits to viable relationships with Canada and British Columbia, where all members are equal partners in the process and which include shared accountability for attaining a First Nations health status that meets our own standards of wellness.

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[2] *Leadership Accord between the First Nations Summit and the Union of British Columbia Indian Chiefs and the BC Assembly of First Nations*, March 17, 2005.
[3] *The New Relationship*, April 13, 2005.
[4] *A First Nations – Federal Crown Political Accord on the Recognition and Implementation of First Nations Governments*, May 30,2005.

Principles

1. The health sector providers of all jurisdictions[5] must respect that British Columbia's First Nations have a special relationship with the Crown as recognized in the Canadian Constitution and further defined by Treaties and self-government agreements. The fiduciary responsibility of the Crown to the health of First Nations people is central to this special relationship.
2. First Nations people have a right to universal and timely access to health services regardless of their economic status, age or gender or place of residence.
3. All jurisdictions must recognize that culture, including language and tradition, is essential to the growth of First Nations as independent, self-supporting people and, that all services to First Nations people, families and communities will be culturally competent in their design and delivery.
4. The network of First Nations managed and governed health service organizations represents a distinct and essential element within the health system of British Columbia.
5. First Nations, Canada, British Columbia and its regional health authorities all have interests in the health of First Nations people. All of these jurisdictions have critical roles to play in achieving the desired vision for healthy First Nations. All will work with integrity to achieve efficiencies and optimal effectiveness through partnership, collaboration and co-operation at all levels.
6. British Columbia First Nations must fully participate in meaningful ways at all levels of the health sector, in the governance, decision-making, planning, delivery and evaluation of health services to our people.
7. Canada and British Columbia must work in partnership with First Nations in the development of public policy aimed at improving First Nations health through the eradication of poverty in our communities and amongst our people. This must include commitments to: quality education, employment and economic opportunity, suitable housing, appropriate policies to nurture and protect our families and children, safe working conditions, and the elimination of systemic barriers such as institutional racism.

Action Agenda

1. Delivery and Access

a) Identification of gaps and barriers in service delivery and coverage.

- The jurisdictional barriers between services for First Nations people living on- and off-reserve remain firmly entrenched in most areas of the health and social services sector. The effect is familiar to us all. Services are denied. Access is limited.
- Gaps and barriers to service delivery are created when health programs are often separated from each other and from closely related social development and education programs and services. Inter-disciplinary team approaches to addressing health determinants are not widely supported.
- The lack of cultural competence[6] of many care providers in provincial and regional health services, private practice (physicians), labs, pharmacies, outpatient services is a

[5] "All jurisdictions" include: First Nations, Canada and British Columbia.

[6] Care that is sensitive to the differences individuals may have in their experiences and responses due to their heritage, sexual orientation, socioeconomic situation, ethnicity, and cultural background. It is care that is based on

significant barrier for First Nations people in their attempts to access health services in British Columbia.

- The geographical barriers for our First Nations in rural, remote and isolated regions of the province are significant with respect to the availability of health services for their people, most of whom must leave their communities to access any services at all. For example, First Nations children with complex health needs are sometimes still placed in care so that they can receive the services that the parents of other children in British Columbia take for granted.
- Gaps in health services for British Columbia's First Nations include, but are not limited to: a significant lack of access to existing services for our people with disabilities, including services which are routinely available to non-First Nations people; First Nations women have less access to health care than other women in British Columbia, particularly those living in rural communities; a serious and debilitating crisis for our people in oral health as a result of limited access and financial barriers to dental care; and, a serious gap in services in the mental health and addictions field including insufficient detoxification beds.
- The minimal recognition and coverage of traditional/non medical interventions and alternative therapies by Canada and British Columbia is a gap in service delivery.
- The resourcing of small independent First Nations in British Columbia is inequitable and does not adequately address diseconomies of scale and is a significant barrier to local services[7]. An assessment of minimum base requirements to meet functional capacity should be undertaken and acted upon. Per capita approaches to funding are a significant impediment in British Columbia where so many of our First Nations have small service populations.

b) Identification of successful initiatives and practical measures that are already in place.

- British Columbia's First Nations have experienced high levels of success through their development of successful initiatives and practical measures that are planned, implemented and evaluated under their own direct control. Often this is in spite of policy or resource constraints that are imposed externally and without the benefit of collaborative relationships with other jurisdictions.
- The almost universal practice of First Nations in adopting our own indigenous approaches to the delivery of our health services is a successful initiative in British Columbia.
- 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. The recent national evaluation of the Transfer Policy identifies numerous successes despite failures in government policy and practice that have undermined our development. British Columbia First Nations must be involved in the planning processes for the implementation of recommendations and remedial actions that flow from this evaluation.

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understanding how those differences may inform the responses of people and the processes of caring for them (Meleis, 1999).

[7] *Entrenched Incapacity: The rights of small independent First Nations in the delivery of health services*, Inter Tribal Health Authority, 2004.

- Many of British Columbia's First Nations or their mandated health agencies manage the medical transportation benefit of FNIHB's Non-Insured Health Benefits program, unlike in other regions of the country. Although the requirement to apply the government's directives and budgetary cutbacks have caused difficulties and hardship, overall it must be considered a successful initiative.
- The development of multi-community health organizations with mandates from member Nations to provide services is a successful initiative in British Columbia.
- Other successful initiatives include: the employment of a limited number of First Nations health professionals by all jurisdictions; the development of community health programs through the employment of local First Nations people; the establishment of an addictions network of community prevention specialists and residential treatment programs throughout the province; the residential schools healing initiatives of individual First Nations, the Indian Residential Schools Survival Society and the Aboriginal Health Foundation; the dental therapists program of FNIHB; the Health Careers and Headstart programs; and, the hospital liaison program of most regional health authorities.

c) *Identification of new initiatives that will improve delivery of and access to health services for First Nations people.*
   - The inclusion of an escalator clause in transfer agreements between First Nations and FNIHB is an essential initiative for improved delivery of health services to First Nations people in British Columbia. Such an initiative should be retroactive to allow for First Nations health programs to catch up.
   - The conversion of targeted programs for inclusion within the global budgets of transferred funding agreements is another necessary initiative that would enhance delivery and access.
   - Canada should support the development of business plans that provide for alternate First Nations utilization of Non Insured Health Benefit resources such as the employment of dentists, pharmacists and optometrists and the development of services that will offset the need for medical travel. Aboriginal Business Canada and Indian and Northern Affairs Canada should identify dedicated economic development support to incubate and implement these business plans.
   - Canada and British Columbia should jointly contribute capital and operating funds to the establishment of First Nations regional health facilities where physicians, dentists, primary care personnel and other professionals receive incentives to work in partnership with First Nations. These new centres should be designed and managed to promote collaborative inter-disciplinary team and outreach approaches, with the participation of all jurisdictions.
   - Some First Nations health facilities should be designated as *centres of excellence* in areas such as, but not limited to, mental health, environmental health, maternal and child health and telehealth. These centres should operate with region-wide mandates; and, functions that are currently performed by federally employed public servants related to these areas should be devolved through third-level transfer agreements.
   - Canada must transfer its third level nursing functions and associated budgets to First Nations mandated agencies that have the capacity to carry out the nursing management responsibilities of the FNIHB regional office, including recruitment, in-

service training, practice consultation, etc. Such transfers must not restrict the development and implementation of new and distinct First Nations models within the *Standards of Nursing Practice of British Columbia*.

- Canada, in partnership with British Columbia should provide real and meaningful incentives to First Nations health centres, willing and able to open their services to local populations, regardless of status or residency. In the First Nations health system, the principle that "nobody will be turned away" should be adopted by First Nations health centres, without fear of financial loss, or other penalties.
- British Columbia should enhance its provincial hospital liaison program to ensure accountability to First Nations and provide a full range of support in major hospitals along the lines of the program at Whitehorse General Hospital and other best practices in other provincial jurisdictions.
- All jurisdictions should support and further nurture the role of the provincial Medical Officer of Health as an independent "watchdog" with respect to Aboriginal health in British Columbia. The scope of his purview should be expanded to include surveillance of progress by all jurisdictions to address the determinants of health in First Nations communities. All jurisdictions should participate in a joint review and planning process through which a collaborative plan is developed to implement the recommendations that flow from the provincial Medical Officer of Health's Annual Report. Professional bodies, academic institutions and other players should be invited to participate, as needed.

d) *Identification of First Nations health human resource and infrastructure development requirements, and how these could be achieved.*
   - All jurisdictions must commit to a comprehensive assessment of the full range of human resource requirements, carried out by British Columbia's First Nations. The assessment must include all health vocations and professions and form the basis for planning of new federal investment in First Nations health careers. British Columbia must ensure the future availability of seats within the health-related programs of its colleges and universities. All jurisdictions must adopt the principle that no First Nations student who is admitted to an accredited program will be denied because of financial support.
   - Human resource planning and actions must be integrated within a comprehensive approach to support the development of our children to realize their fullest potential, including critical support for the period *conception to five years*. Medium term actions should include special efforts targeted to the "Headstart kids", the oldest of whom are now only 5 or 6 years away from high school graduation.
   - Canada must revise its allocation formulae for transfer agreements to ensure that funding for the First Nations health infrastructure enables the capacity to offer competitive salary and wage levels for like work across jurisdictions. First Nations and their mandated health agencies must be able to offer competitive and equal employment opportunities.
   - Major investments by Canada and British Columbia are required in the development of First Nations information management, human resources and information technology. The provision of high-speed broadband Internet access to First Nations

must be a priority in opening distributed learning opportunities to community health workers and, in the delivery of e-Health services.

- Post secondary institutions offering education in the health professions must focus on the further development of career ladders that increase the opportunities for First Nations people to enter the health professions at various levels receiving full credit for related diplomas and certificates received in the past. For example, a career ladder in nursing could include initial entry after high school into a personal care attendant certification course, followed by entry into a licensed practical nurse diploma, registered nursing, and bachelor of nursing where each new level is built on the previous educational module, but also has an optional endpoint.
- Recruitment and retention strategies for health care providers should be jointly developed and implemented across all jurisdictions. All jurisdictions should accept that First Nations health care professionals should be involved in a meaningful way in the development and implementation of recruitment and retention strategies for health care professionals working in First Nations communities.
- Canada and British Columbia must collaborate with First Nations to develop a consistent, transparent, and adequately funded capital planning process for First Nations health care facilities and major equipment. Multi-disciplined health centres and other related facilities that serve First Nations from birth to death should be the goal.

2. **Sharing In Improvements to Canadian Health Care**

a) Identification of existing mainstream initiatives that require participation of First Nations.

- Canada and British Columbia must ensure that British Columbia First Nations are able to fully participate in the ongoing debate concerning a two-tier health care system. First Nations people are the least likely to benefit from private services and the most vulnerable to a diminished public system.
- Canada and British Columbia must ensure the participation of First Nations in primary health care transition and innovation development, including:
  - *i.* The restructuring of MSP physician billing mechanisms to reward interdisciplinary and integrated approaches to service;
  - *ii.* The recognition and promotion of Nurse Practitioners; and,
  - *iii.* The Strategic development and implementation of policies and programs that support the infrastructural and operational success of telehealth and e-Health initiatives for First Nations. Information and communication technology-enabled services will improve access to cross-disciplinary services and ensure that First Nations have the capacity to keep pace with parallel developments within the Canadian healthcare systems.
- All jurisdictions must recognize and act in concert with First Nations to respond to the prevalence of prescription drug abuse, and to mitigate the adverse affects of abuse on First Nations. This issue must be treated as a mainstream prevention initiative with multi-faceted downstream consequences for the well being of our people. This initiative must be linked across jurisdictions and recognize the connection between abuse and actions required in supporting oral health and addictions prevention.

- Canada and British Columbia expend tens of millions of dollars annually on research that is related to First Nations health and wellness. Increasingly, these jurisdictions and their institutional partners are recognizing the importance of community-based and controlled research methods. There is a lack of capacity within the First Nations health care system to develop and sustain our own research agenda and a practical consensus that research partnerships yield the most innovative and useful results. Mainstream research initiatives that are more inclusive of First Nations involvement should feature the designation of First Nations health research centres at regional levels of the province.
- The mainstream health care system must recognize the unique place of midwifery in First Nation communities and the role of midwifery in the holistic view of childbirth. Midwifery is not accessible to most First Nations women living in poverty or in rural areas. Many of our women are forced to leave home to give birth to their babies in regional hospitals, great distances away from their families. This is a form of neo-colonialism that will result in the further loss of our culture, particularly as it relates to the welcoming of new babies into our Nations.

b) *Identification of ways to improve health services to all First Nations people that flow from the First Ministers' 10 Year Action Plan.*
   - The incorporation of First Nations indigenous approaches to health and well being into mainstream service models across all jurisdictions of the health care system in British Columbia would be a major step towards the improvement of health services for our people. This should include, but not be limited to, direct and specific actions that mitigate systemic racism and targeted in-service training for non-Aboriginal health service providers throughout the province to improve their capacity for culturally competent care.
   - British Columbia must require that curricula for all education programs for health care providers that are designated under the *Health Professions Act* include strong content related to cultural competency and inter and intra-disciplinary team approaches to health care delivery.
   - All jurisdictions must commit to the access provisions under the *Canada Health Act* for First Nations people. First Nations families should have timely access to culturally sensitive continuing care services and facilities regardless of whether they are living on- or off-reserve. This must include the development of a continuing care capacity in First Nations communities to keep people close to home and close to families.
   - All jurisdictions must commit to primary care reform measures that include joint strategies for addressing cross-jurisdictional barriers of service between agencies, institutions, private practitioners and reporting bodies. Primary care reform will be enabled by a comprehensive implementation of health information systems and concomitant negotiation of jurisdictional sharing agreements. Clinical information systems implemented in First Nations controlled health services will meet the criteria set out in accordance with the OCAP principles (Ownership, Control, Access, and Possession) and comply with electronic health record system standards. Canada must commit the necessary funding to support the electronic sharing of data elements with

provincial and federal systems, as determined through negotiations between First Nations and the provincial and federal governments.

- All jurisdictions should accept and build on the advice of the Health Council of Canada[8] pertaining to Aboriginal health, including the development of an Aboriginal health work force; an aggressive approach to encouraging Aboriginal youth to consider health careers; the development of health professions training programs that recognize traditional healing practices; the development of primary health care models to address the broader social determinants of health; and, the accelerated use of information technology to improve services in Aboriginal communities.
- All jurisdictions must commit to the inclusion of First Nations' health prevention and promotion activities into daycares, schools, and continuing care facilities used by First Nations families.
- All jurisdictions must commit to the development of a British Columbia First Nations "*Health Innovations Plan"* through partnerships between First Nations, NGOs, regional health authorities, education institutions, and professional bodies. Such a plan must encourage the development of research approaches in which best practice and evidence guide the planning, implementation and evaluation of a new continuum of care that is culturally sensitive and meets prevalent health needs of First Nations people.
- The *"Improving Access"* provision of the Ten Year Plan must recognize that an essential tool available to First Nations to ensure access to the health care system is the medical transportation benefit of Canada's Non-Insured Health Benefits program. The critical importance of this benefit to our people must not be underestimated, particularly for our people who live in rural and remote communities. British Columbia does not offer its citizens a medical transportation benefit regardless of their circumstance. British Columbia First Nations fear that Canada's interest in a more synchronized health system will lead to the deletion of the medical transportation benefit. Our leaders will resist any attempts to delete this benefit. All jurisdictions must commit to working together to better understand the importance of the medical transportation benefit and to creating ways to enhance its application in improving access by our people to necessary health services.
- The collective management of Medical Transportation by First Nations in British Columbia has resulted in the lowest per capita expenditure anywhere in the country—by a considerable margin. Canada must recognize this fact in the determination of budgetary allocations to its regions. The budgets of other FNIHB regions with consistent over-expenditures or management problems in Medical Transportation have been historically "bailed out" by FNIHB Headquarters, while budgetary reference levels for its Pacific Region are cut back when efficiencies are achieved.
- The *"Strategic Health Human Resource Action Plans"* component of the Ten Year Plan is also important to British Columbia First Nations. The Plan's objective to increase the supply of health care professionals resonates throughout our health system and is discussed elsewhere in the Blueprint. The recent decision by the University of British Columbia to allocate a percentage of seats in its medical school to Aboriginal students is a step in the right direction. First Nations in British

[8] *Health Care Renewal in Canada,* 2004.

Columbia are committed to working with British Columbia and all post secondary institutions towards the development of similar policies. Many of our students have been unable to gain admission to nursing programs in the province because of demand. This is not acceptable to First Nations in British Columbia.

- The *"Home Care"* component of the Ten Year Plan must recognize that the current FNIHB Home and Community Care program is restricted to on-reserve residents and has many deficiencies that must be addressed. First Nations people carry a disproportionate burden of disease and disability and require a wide range of home care services that must be planned, delivered and evaluated in culturally appropriate ways. The current program is significantly under funded and imposes unreasonable reporting requirements on First Nations health managers. The program must be reformed to:
  - *i.* Ensure that a full range of home care services (Elder's day programs, meals on wheels, home care nursing, speech, occupational and physical therapy, medical and other supportive equipment, personal care, and homemaking services) can be provided to both on and off reserve members, including frail Elders and people of all ages with disabilities.
  - *ii.* Enable First Nations to develop their own culturally appropriate models of home care delivery and reporting mechanisms that are meaningful and support the organization and delivery of care across the home care spectrum.
  - *iii.* Provide adequate funding within the global budgets of First Nations and their mandated health agencies, rather than through targeted funding agreements.
- Funding for the special housing needs of First Nations people with disabilities and, the establishment of continuing care homes for all levels of care within First Nations traditional territories is a natural extension of the home care program.
- The "*National Pharmaceuticals Strategy*" component of the Ten Year Plan must:
  - *i.* Ensure that no First Nations person is denied access to life-saving drugs because of an inability to pay.
  - *ii.* Monitors the prescribing behaviours and patterns of physicians and addresses the problems both with individual physicians and their patients. An aggressive campaign in First Nations communities and amongst First Nations health care providers must be initiated concerning the many threats to health posed by these practices.
  - *iii.* Encourage First Nations, wherever possible, to own and operate pharmacies and other related business ventures on reserve, so that we can share in the huge profits available to others in the health sector.
- The *"Prevention, Promotion and Public Health"* objectives of the Ten Year Plan are supported by British Columbia's First Nations. The First Nations health care system has, by necessity, focused on prevention and health promotion throughout its evolution. Our developmental support has come essentially from Canada, which has invested in the public health sector of our system, while contributing to our access to medical services through medical transportation, the payment of premiums for our coverage under the provincial medical services plan and, through the inclusion of our population statistics in the calculation of transfer payments to British Columbia. Some provincial officials would have us believe that the combined effort of Canada and First Nations has been inadequate in offsetting the numbers of our people that end

up drawing on their Medicare program. Our view is that service gaps, compromised health status and escalating medical costs stem from the failure of jurisdictional collaboration, combined with a lack of provincial support for our prevention and promotion efforts and, that these consequences reflect the failure of both governments to effectively address health determinants through adequate investment in housing, education and economic and employment opportunities.

c) *Identification of ways to increase participation by First Nations people in more effective planning, delivery and evaluation of First Nations health services.*
   - British Columbia First Nations support the continued existence of the First Nations and Inuit Health Branch of Health Canada as a distinct operational entity. For better or worse, we have a longstanding relationship with FNIHB (formerly Medical Services Branch). "The Branch" continues to provide a national and regional focus for the health issues that afflict and define our people. The actions of Health Canada to restrict the freedom to act of FNIHB through the centralization of its administration and financial management functions under a "Corporate Services" Branch are viewed with concern. The transfer of FNIHB functions, whether internally within Health Canada or externally to other governments, agencies or institutions—other than First Nations or their mandated organizations—must be undertaken with the full involvement of our leadership.
   - During the mid-nineties, a Transitional Management Strategy was developed by a joint committee of the senior management personnel of the FNIHB regional office and the Chiefs' Health Committee of the First Nations Summit. The vision of the committee and the purpose of the strategy was to create a First Nations operated regional health agency through a phased approach. As the transfer of control to our Nations increased at local levels, it was envisioned by both sides that the responsibilities of the FNIHB regional office would decrease until the remaining functions would be totally assumed by one or more regional First Nations health authorities. In 1998, this vision was rejected by the Assistant Deputy Minister because of a "policy void" related to the transfer of third and fourth level functions.
   - The idea of eventually converting the regional operations of FNIHB to a provincial First Nations agency still has merit, in the view of many First Nations. The creation of the Pubic Health Agency of Canada (PHAC) and the National Aboriginal Health Organization (NAHO) offer models for the consolidation of leadership in public health at the national level. A revival of the "transitional" approach could begin with the assumption of control of the FNIHB regional infrastructure by a Board of Directors with multi-jurisdictional representation and lead, over time, to a First Nations-controlled agency with links to PHAC, NAHO and the Provincial Ministry of Health. Other models should be considered although discussions with Canada although such deliberations should be led by a central agency rather than Health Canada.

3. Promoting Health and Well-Being

a) *Identification of priority areas for investment in First Nations health promotion and disease prevention.*

- The "priority areas for investment in First Nations health promotion and disease prevention" have been identified in countless studies, reports, proposals, position papers, and correspondence over many decades. Our leaders have made countless representations to Canada and British Columbia in which priorities have been declared and needs described. Reports from the Provincial Medical Officer concerning alarmingly high rates of First Nations diabetes, mental health and other chronic illnesses even make headlines in the daily newspapers.
- The requirement that is set out in the Blueprint template for the further identification of "priority areas for investment" has been carefully considered. The response is simple: our children are a priority; our women, our families and our elders are a priority. Our people with disabilities are a priority. This isn't a difficult question. The participants at the Blueprint Forum on June 22nd, 2005 didn't hesitate when asked to identify priorities. There ideas can be found in the appended *Forum Proceedings*. Beyond this, the Blueprint will not attempt to identify detailed health promotion investment priorities of British Columbia First Nations. Instead, it will reiterate the principles on which such priorities must be identified.
- Elsewhere in this Blueprint, the point is repeated that British Columbia First Nations aspire to a health care system that is designed and delivered within their own communities by their own people, in keeping with their own unique cultural ways and traditions. Other characteristics are also identified including, holistic approaches, addressing the determinants of health, inter-disciplinary actions, etc. It is through local processes that are structured with these features that priority actions and the methods and techniques that are used in promoting health and preventing disease will be defined.
- Increasingly, First Nations health managers and workers in British Columbia are concluding that the government's old approaches to health promotion do not work for our people. The notion that chronic illness is mostly life style related and can be addressed through public education campaigns such as brochures, posters, and lectures at workshops is not credible. They are too often victim blaming. The failure of funding programs that adopt these approaches and operate in isolation one from the other have limited application in dealing with the complexity of issues facing our people.
- The first priority for investment in promoting First Nations health is to liberate First Nations from the constraints of restrictive government funding arrangements. This priority has been expressed elsewhere in this document but has a particular relevance when considering the need to *invest.* The question is asked: where to invest? Surely the answer is to invest in community development processes that support First Nations and their mandated health agencies to determine there own courses of action based on their understanding of the complexities that must be addressed.
- Current approaches to investing in First Nations health lack the fundamental understanding of complexity and cultural context that must form the basis of health actions in health promotion. The current investment practices of Canada and British Columbia demonstrate a lack of fundamental understanding that, for example, there are linkages between a child's mental health and her oral health and her self-identity and whether her parents were in residential school and the attitude of the pharmacist when she observed the way her father was treated when he picked up a prescription.

Otherwise, why would government funding be provided through funding "silos" that categorize needs and prescribe actions?

- Needless to say, the development of First Nations models of health is a priority for investment in health promotion and disease prevention. Such models will always be holistic in their approach to health promotion and disease prevention. The development, testing and publication of First Nations models based on best practice and Aboriginal perspectives is a priority in health promotion.
- The development of health services that reflect First Nations cultural values and extend the opportunities for health services to practice First Nations ways of health and healing should be a priority across all jurisdictions.
- The reduction of provincial inequalities in health should be a priority for investment and requires a focus on actions where a difference can be made. Population health objectives must be identified, through an inclusive process that involves all First Nations in British Columbia. Regional health authorities must respond to the distinct First Nations goals within their regions, and identify service coverage and areas that need to be strengthened or modified over time.
- The development of First Nations quality of living indicators through research initiatives that focus on our own ways of locating and sharing knowledge is a priority.
- Early childhood development is a major priority because it has the largest potential impact and carries the requirement for a major cross-jurisdictional effort.
- First Nations women's health from cradle to grave is a priority. Poor access to health care and the lack of programs for these populations result in increased spending in health care.
- The provision of acceptable standards of care for our people with disabilities is a priority, including timely assessment, diagnosis, treatment and rehabilitation. This must be addressed through a commitment by all jurisdictions to develop comprehensive, multi-sectoral strategies. FASD is an example of a disability that requires a comprehensive community response.
- Mental health and addictions is a priority; grief/loss; re-trauma[9]; detoxification services; supportive recovery; re-entry; and, life skills development. Substantial investment is required in the development of mental health and wellness care as a core component of First Nations health programs. All jurisdictions must understand the consequences of multi-generational trauma in the development of their service plans.
- All jurisdictions must adopt "earlier intervention" as a high priority in the First Nations health system.
- All jurisdictions must commit to the development of plans to address areas of priority through: training of providers in early identification and assessment; use of best practice guidelines for care and support; and, a shared care approach, beginning with the individual and the family and including referral pathways to specialists, outreach programs and community-based and multi-sectoral follow-up.

[9] *BC Provincial Mental Health Advocate's Report* (2000), defines re-trauma as "the trauma associated with the care system…people, particularly women who have been assaulted or abused in the past, often report the mental health system as reactivating that original trauma".

b) *Identification of how to facilitate a holistic approach to First Nations health that links with the key determinants of health.*
   - All jurisdictions must recognize that First Nations families are supported within a wider network of structures within their own communities. This must lead to a community development approach that builds on the assets and strengths of healthy families and communities.
   - All jurisdictions must consider a fundamental shift in the focus of health care delivery from "individual as the client" to the "community as the client".
   - All jurisdictions should commit to the implementation of the *First Nations Health Reporting Framework* as a first essential step to redefining the First Nations "health landscape". The *Framework* is, as close to a comprehensive perspective of First Nations health as has been developed to date and all players should adopt it without delay.
   - All jurisdictions must commit to the basic requirement of cultural competent service providers. First Nations developed and delivered education and training programs will be the most appropriate vehicle for the ongoing support of this requirement for all jurisdictions and at all levels.

c) *Identification of existing successful initiatives on which to build.*
   - The most significant successful initiatives in the implementation of promoting health and well-being can be found in those activities that are planned, implemented and evaluated by First Nations. The funding arrangements that permit First Nations to define their own needs, objectives, actions and success measures allow for the greatest likelihood of successful outcomes. For the most part, these successful initiatives are found within the First Nations communities that have accepted the transfer of health service delivery from FNIHB, notwithstanding the limitations of its transfer policy.
   - The least successful outcomes are those First Nations initiatives which are supported through targeted funding agreements, which carry administrative and reporting requirements that are excessive, which are project oriented rather than comprehensive, which impose sunset requirements that discourage ongoing planning and the employment of qualified staff and which force partnership relations that aren't natural and for which the "partners" are not prepared.
   - Many British Columbia First Nations have been successful in creating health systems that are founded on the principles of community development. It is not necessary to leave BC to find the experts: Gitxsan, 'Namgis, Nuu-chah-nulth, Carrier-Sekani, Kwakiutl District Council, Heltsuk, Waglisla, Cowichan Tribes, Massett, Skidegate, Nisga'a, Seabird Island, Inter Tribal Health Authority, Heskw'en'sutxe, Chehalis, Esketemc, Tsawout, Tl'azt'en, Sto:lo Nation, Sliammon, Snuneymuxw, Sh'ulh-etun, Ktunaxa/Kinbasket…a partial list of British Columbia First Nations and mandated health organizations that have built successful primary health care programs, rooted in the principles of community development.

4. Monitoring Progress and Learning As We Go

a) Identification of ways to determine if we are making progress.

- Evaluation and monitoring is a complex, multi-stakeholder dimension of the health sector. Currently there is significant categorical confusion around this undertaking. This confusion is in part due to the numerous theoretical approaches to evaluation and monitoring. More importantly, it is due to two conflicting driving forces behind evaluation and monitoring: accountability to funders; and, program/organizational level requirements for lessons learned to help feed into their planning processes for the future.
- The risk of not having a clear conceptual separation between accountability mechanisms and organizational evaluation activity is that funding bodies (e.g. government departments or ministries) will hijack the program planning and monitoring process to suit top-down accountability requirements. The result is often a devaluing of the importance of evaluation at the First Nations community level--and, evaluation and monitoring becomes an irritating hoop to jump through to please the funders and help ensure continued funding, rather than an important learning mechanism that facilitates both good strategic decision making and the telling of the ongoing story of the First Nations community health system and its impact. The emphasis of evaluation and monitoring as a means of accountability to funders frequently results in the undermining of local autonomy and self-determination. Top-down evaluation frameworks, and the selection of universal indicators and data elements, will inevitably dictate how programs are conceived, designed and rewarded.
- All jurisdictions must acknowledge and enact the separation of accountability mechanisms from program and organizational evaluation. Clearly there must be a cross-over and dialogue between the two streams, but they must be independently motivated/driven. For instance, an element of an accountability requirement would inevitably be the need for organizations/programs to entail evaluation as a regular part of the planning cycle; but this accountability requirement should not thereby co-opt the evaluation process itself. Another example is reporting – both accountability mechanisms and evaluation processes will require reporting requirements and ongoing data gathering. However, the specification of program reporting requirements has more often been driven by accountability interests – i.e. reporting to funders about how money is used; or, establishing a relationship between changes in health status and funding. First Nations need to reclaim a significant element of reporting exclusively for the organizational evaluation and planning cycle.
- The adoption of a clear distinction between these interrelated, but very different, dimensions to the First Nations health sector must be acknowledged by all jurisdictions. This will involve the basic distinctions of:
  - *i. Organizational/Program Evaluation and Monitoring:*
    - Designed to meet the planning and monitoring requirements of the First Nation: was the organization effective & efficient in executing its intentions; what lessons were learned on what worked and what didn't, and what projections/suggestions for what would work better in the future; what are

structural/systemic barriers and gaps; what are the changes in relations with partner organization and stakeholders?
- Oriented to the strategic direction and needs of the organization.
- Focused *not* on "results/impacts" – ie. Changes in state (such as changes in health status), but rather on output, outcome, performance, and process.
- Evaluation methodology determined by the First Nation or mandated organization according to local requirements and evaluation objectives; broad range of possible approaches, including participatory action evaluation, accreditation, process evaluation, and continuous quality improvement.
- Evaluation results intended primarily for organizational governance and management for feeding into strategic planning cycles.
- Data collection and gathering requirements determined to meet needs of local evaluation.

ii. Regional/National level health and policy research/evaluation:
- Research or evaluation initiatives undertaken to attempt to measure change in state over a large geographical area.
- Focused on the measurement of health indicators and change in health status.
- Identification of cause and effect relationships between services or conditions and change in health status, where possible.
- Scientifically and statistically rigid in application.
- Example: the First Nations Longitudinal Regional Health Survey (RHS).
- Served by multiple level of impact.
- Support by the development of the *First Nations Health Reporting Framework* (FNHRF) by the AFN, as an overarching national approach to reporting. The twenty-defined indicators appropriately have the Regional Health Survey (RHS) and the census as the data sources, rather than program/organizational level data collection. The model of four health domains and eight subsections effectively captures a holistic perspective of health services.

iii. Accountability Monitoring:
- Mechanisms for measuring, monitoring, and ensuring obligations for the fulfillment of responsibility.
- Multi-directional/level: First Nation to funder; funder to First Nation; funder to taxpayer/donors; First Nation to service population; funder to service population.
- High level monitoring and measurement of effective & efficient performance.
- Risk-management function concerning the inappropriate utilization of resources.
- Data collection & reporting requirements related specifically to agreed elements of responsibility, but not to change of state (eg. change in health status).

        - May utilize data from Program/Organizational Evaluations and/or Regional/National level health and policy research evaluations as secondary sources for informing assessment of accountability.
    - A blurring of these essential levels of evaluation and monitoring leads to confusion and potentially disempowers self-determination at community levels.
    - First Nations in British Columbia support a developmental approach to organizational/program level evaluation, which is clearly distinguished from both regional and national program evaluation, policy research and evaluation and accountability measurement. Although the selection of approach must be made at the community level, one effective model for a developmental approach is *Outcome Mapping*[10], designed by the International Development Research Centre and used widely around the world. Its' authors make offer the following perspective:

      "Evaluation and monitoring at this level must be seen first and foremost as a tool for measuring change, strategic decision making, and shared learning. It is not primarily an accountability mechanism to funders. An overemphasis on the funder's (i.e. government's) need for attributing impact to funding and a concern over risk management, has detracted from the learning potential of E&M. This has lead to an over reliance on bureaucratized "logical framework analysis" models and "results based management" frameworks."

      "Linear, "cause and effect" thinking contradicts the understanding of development as a complex process that occurs in open systems. Pressure to demonstrate, measure, and be accountable for impact has led donors (funders) to conceptualize, implement, and evaluate programs using tools and methods which seek a linear cause and effect relationship between a problem and the identified "solution" to that problem. However, experience tells us that development is a complex process that takes places in circumstances where a program cannot be isolated from the various actors with which it will interact (for example, other donors, partner organizations, government departments, communities, organizations, and groups within the community). Nor can it be insulated from the factors by which it will be influenced (these include social, political, cultural, economic, historical, and environmental factors)." (Outcome Mapping, Earl, Carden & Smutylo, 2001)

b) *Identification of ways to proceed respectfully and effectively to monitor and evaluate programs.*
    - The principles of Ownership, Control, Access, and Possession (OCAP) must guide all health information management and data collection activities in the First Nations health sector.
    - Health Informatics capacity and infrastructure, as well as Evaluation & Monitoring expertise must be properly resourced for First Nations and their mandated health organizations, in terms of human resources, operations, and capital.
    - Health Information Systems that are rooted in the principles of OCAP, such as the Musti'muhw system, owned and developed by the Cowichan Tribes on Vancouver Island, must be supported and funded for First Nations use. Such systems will allow

[10] *Outcome Mapping*, Earl, Carden and Smutylo, International Development Centre, 2001

First Nations to enter into multiple and varied data sharing agreements with various health sector partners according to their own determination.

- All jurisdictions must jointly determine local data sharing arrangements around which data elements are to be shared between jurisdictions and regions. Sharing of data is a two-way street. All parties need to develop agreements, protocols and systems that will ensure that the transfer of data is from the First Nations organization to the federal/provincial/regional authorities and vice versa.
- The collection of program reporting data in the past through government designed systems has not been successful and incurred significant public expenditures. These systems have focused on gathering "activity" and "output" data as a means of measuring accountability. This has proven useless and burdensome--not only to First Nations, but to the First Nations and Inuit Health Branch (see *National Transfer Evaluation*). The requirement to collect and report data to funders should be exclusively focused on accountability elements, not on either program/organizational evaluation or data for roll up for the purpose of national/regional health and policy research evaluations.
- Important aspects of consideration in both local evaluation, as well as national and regional health and policy research/evaluation are:
  i. A belief in Nation-building and the sovereignty of First Nations governments.
  ii. Culture as a primary resource for success.
  iii. A focus on the strengths of community, individuals, programs and institutions.
  iv. The community development process as a means of increasing capacity.
  v. Proactive change and shared learning.
  vi. A focus on the expectations, goals and concerns of the organization.
  vii. An emphasis on the future use of the information and the evaluation report by the organization.
  viii. A flexibility that recognizes the uniqueness of each community and the organizations that serve them.
  ix. A positive orientation that looks to the strengths of the community and the organization.

5. Clarifying Roles and Responsibilities between Governments and Organizations

a) Identification of where current roles and responsibilities create barriers to improving health outcomes or services.

- Current roles and responsibilities are characterized by enormous inequities between the federal and provincial governments and First Nations. These relate to orders of magnitude that need not be documented here. Needless to say, in comparison to First Nations, Canada and British Columbia dominate with respect to the human and system resources that are applied to carrying out their policy, planning and program roles and exercising their service responsibilities. This is true at all levels. Legal, clinical, evaluative and administrative resources are routinely deployed by the governments in the development of legislation and policy and the planning and delivery of services. This is in stark contrast to the very limited human resources and system infrastructure available to First Nations. This imbalance is not off-set by a policy environment that effectively yields to (or at least, recognizes) the paramountcy

of British Columbia First Nations in defining their own needs, planning their own actions, controlling their own resources or evaluating their own results.

- Too frequently, Canada and British Columbia use proxies for First Nations "input" (e.g. focus groups) or superficial consultative processes (occassional workshops) to validate policies, plans and actions that are conceived in Ottawa or Victoria. Mostly these efforts are well meaning but do not usually result in accurate assessments of community need or potential. Too often, First Nations and their mandated health organizations are viewed as program delivery units at the end of the policy, planning and delivery stream.
- Federal and provincial governments continue to expand the scope and practice of their officials in British Columbia without seriously considering how these roles and responsibilities can be effectively and efficiently performed by First Nations. These roles and responsibilities include quasi-regulatory functions; research and policy and program development; and, the delivery of direct services.
- British Columbia First Nations leaders frequently observe that there is a "disconnect" between the stated policy intentions of Cabinet Ministers with whom they meet and the officials to whom responsibility for implementation is delegated.
- Government officials have difficulty in abandoning the DIAND-style role of regulating the flow of resources allocated by their respective governments. Proposal-driven, project-oriented programs are usually favoured over transfer payments to First Nations governments by officials who are still rewarded on the basis of the budgets that they control and their respective placement on the organization charts. An official who has the responsibility for supervising staff who perform the role of considering and approving funding proposals is more important than one who negotiates a block transfer with a First Nations health agency.
- In the early days of the health transfer policy, there was frequent discussion with the former Medical Services Branch (now FNIHB) about the residual role that would eventually be carried out by the government, once the implementation of the policy reached the point where most responsibility had been transferred to the jurisdiction of First Nations. These discussions have been conspicuously absent from the dialogue with the Branch at regional and national levels over the past seven years. Moreover, the actions of the bureaucracy signal a reverse trend. That is, a steady expansion of its roles and responsibilities rather than contraction. By way of example, when the transfer policy of Health Canada was developed in the mid-eighties, a single Regional Nursing Officer was employed in the Pacific Region. Today 32 nursing officers share that role. This has created a policy void for BC's First Nations. Should our long-term planning include a reduced or an increasing role for FNIHB?
- The responsibility for legislation, policy, planning and control is assumed by different departments and ministries of the governments. Barriers are created and contradictions are entrenched by officials who are unaware of the effect that their mandates have on the mandates of others. It is left to First Nations to make the "stove-piped programs and funding arrangements" work within the reality of their communities, expending limited resources on finding ways to synchronize the activities that are funded under one arrangement with the projects that are supported through another department of the government.

b) *Identification of practical changes that will help achieve our goals, that will address issues in roles and responsibilities, and build towards solutions.*

- The recent Leadership Accord between our First Nations representative organizations formalizes a cooperative relationship to politically represent the interests of First Nations in British Columbia. The New Relationship vision and plan has been jointly developed with senior officials, with the support of the Premier and is currently scheduled for Cabinet review. This important document includes agreement to create new institutions or structures for shared decision-making regarding and is expected to form the basis of the government-to-government relationship for the long term.
- As reported elsewhere in the Blueprint, the regional office of the FNIHB and the Chiefs' Health Committee established a Transitional Management Committee of Health Canada senior officials and First Nations representatives in 1997. Its purpose was to work towards the assumption of an optimal level of control by First Nations over federal responsibilities for First Nations health service management. The Committee was abandoned in 1999, following the collapse of its joint proposal to transfer the Environmental Health program to First Nations control and the pronouncement by the Assistant Deputy Minister that a "policy void" prevented the transfer of the third level services of his Branch. This experience should be evaluated and consideration given to reviving approach. At the same time, the development of national policies that provide for the transfer third level services to the jurisdiction of First Nations should be initiated at the national level.
- It is not practical to expect that the issues related to roles and responsibilities can be addressed or solutions built without a correction in the imbalance of resources that are available to the players at all levels of the health care system. Elsewhere in this Blueprint, the need for the effective participation of First Nations representatives at all levels of the governance of the health care system is identified. The cost of this representation must be realistically calculated and the resources deployed without delay.
- The severe over-reaction of the federal government to the mismanagement of its programs at HRDC and to the criminal actions of its senior managers at FNIHB resulted in serious difficulties for First Nations in British Columbia. Developmental processes were deferred and agreements tightened with additional restrictions and reporting requirements. When systems break down within the governments, a method of including First Nations in the planning and implementation of remedial actions must be devised. It is not acceptable that the government should "circle its wagons" in circumstances of this nature and exclude our leadership from consideration of remedial actions that impact us so significantly.
- In British Columbia, health services are delivered through regional health authorities. These agencies have regulatory responsibilities for the maintenance of safe levels of public health amongst the population within each of their catchments. Their Boards and senior officers each control hundreds of millions of dollars and employ many thousands of health care workers in the management of hospitals, physician services and all the services that make up British Columbia's health care system. Although the Provincial Medical Officer of Health regularly identifies the urgency of addressing the health status of Aboriginal people in his annual reports, First Nations

do not have a meaningful role in determining the directions taken by the regional health authorities. A practical change that will help BC First Nations to achieve our goals and that will address issues regarding roles and responsibilities is a legislated requirement that the Boards of the regional health authorities include within their membership a designated number of seats filled by First Nations appointed Directors. Further practical changes should be charted jointly through a review and development process that identifies regional health authority decision-making processes that should include meaningful First Nations participation.

- The healthcare system is undergoing change at every level, particularly as it relates to the introduction and use of information and communications technologies in home and health settings. While many of these changes address longstanding concerns for First Nations there is no point-of-entry or resources for First Nations to participate in standards settings bodies, such as the Council of Chief Information Officers or to engage federal enabling structures.

c) *Clarification of the meaning of government-to-government relationships in this context.*
   - Government-to-government relationships can only have meaning if, as in any relationship, there is balance. Our nations are small and carry the burden of many complex problems not of our making. We will only hold our own in relationships with Canada and British Columbia, if they are characterized by the principles of *equity*, *trust* and *understanding*.
   - The processes through which we conduct our business must be fair. Too often we are faced with take-it-or-leave-it options. We are forced to turn to the courts or the media in search of a fair resolution of our issues.
   - In the health sector, we are too frequently reliant on the will of the federal and provincial governments. Their officials make the essential decisions about the directions we must take in the health sector. They put some money into the diabetes box, other money into the AIDS box, or the residential-school-legacy-of-physical-and-sexual-abuse box, as if they somehow know better than we do the directions we must take. This point has been repeated throughout this document but it is essential to the definition of a government-to-government relationship that the right of First Nations to govern their own affairs be respected.
   - At the level of legislative development, First Nations must be full participants at the architectural stage, not simply at the ribbon-cutting stage, applauding on the sidelines as Ministers make new announcements. In Ottawa, the Assembly of First Nations is our voice and represents our interests. It is accountable to our local governments and our regional elected bodies and we expect that it will have a *meaningful* role in the development of Cabinet submissions and in the drafting of legislation, including the creation of the federal budget. The Minister of Finance traditionally consults the captains of industry and commerce in the run-up to a new budget. This practice must also be followed with First Nations.
   - In Victoria, the same principles should apply with respect to First Nations involvement in the development of legislation. Multi-sectoral actions that impact on the determinants of First Nations health must be taken across the various mandated Ministries, with our meaningful participation. It will not be effective if the Ministry of Health recognizes the importance of culturally relevant services for our people in

one piece of legislation and the Province reduces social service support or closes schools with other legislation. British Columbia First Nations expect that its leadership will be *effectively* engaged in the legislative process wherever their people and communities are affected, in a concerted and coordinated way.

d) *Description of the importance and necessity of reciprocal accountability and how to achieve it.*
   - For the purpose of this Blueprint, "reciprocal accountability" is defined as "a process through which all parties to a plan, action, agreement, etc. take mutual responsibility for their conduct, one to another". Another definition is: "*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.*"[11]
   - British Columbia's First Nations acknowledge that the idea of reciprocal accountability is important to the future of their relationships with Canada and British Columbia. This is particularly the case within the health care system of British Columbia where the efforts of all service providers are significantly dependent on the efforts of others.
   - The methods used to maintain reciprocal accountability—the responsibility of all parties to each other—require *balance* and must be based on *equity* and *trust*. For British Columbia's First Nations, current methods are neither equitable nor balanced. They are based on the principle of "he who pays the piper, calls the tune" and because the funding is voted in government legislatures, then held in trust and distributed by government officials, the direction of accountability is pre-determined. Top-down control and bottom-up accountability.
   - Currently, the requirements of the governments for First Nations accountability are mostly defined in funding agreements. British Columbia's First Nations do not consider these requirements to be reciprocal in any way. First Nations must explain and justify how resources are spent in order that government officials can justify their work to Ministers who, in turn, justify their actions to Parliament.
   - The achievement of true reciprocal accountability must include principles that are identified elsewhere in this document and include:
     i. A level playing field;
     ii. Transparency;
     iii. Mutual respect and trust;
     iv. A clear responsibility and authority to make the changes that are needed;
     v. A burden of accountability that is equally shared—as it stands now, First Nations bear a disproportionate share of the burden of accountability;
     vi. A fair and comprehensive accountability system; and,
     vii. A process for reciprocal accountability that includes, at a minimum:
       - Delineation of the scope of accountability – i.e. as differentiated from organizational evaluations or regional health and policy research and evaluation;

[11] Elmore, Richard

- The clear identification of key pillars guiding accountability provisions; and,

6. Developing on-going collaborative working relationships.

a) Identification of how we can structure on-going collaborative working relationships in pursuit of our vision.

- The foundation for the on-going collaborative working relationships that will be required in pursuit of our vision is outlined under *Planning Context* on page one of this document. Our leadership understands the magnitude of work that is now required by the parties to these relationships and the importance of structuring processes that ensure forward movement.
- First and foremost, he processes that are established through these relationships must recognize the rights of individual First Nations in British Columbia to identify their own interests. This won't be difficult but processes must be adequately resourced and implemented in a timely manner.
- The announcement by the Prime Minister of the funding to support the integration of efforts between all jurisdictions represents an important source of support to British Columbia First Nations in our efforts to identify our interests and to contribute in a meaningful way to the further development and implementation of the Blueprint in British Columbia. It will not be acceptable for Canada to flow these funds through the provincial government. First Nations must be able to enter into collaborative relationships with British Columbia without having their "hats out" for funding. Such processes are demeaning and not conducive to an effective government-to-government relationship.
- The collaborative relationships that are necessary in the on-going pursuit of our vision must recognize the personal and corporate interests of the parties. It is not effective to charge government officials with the responsibilities for working towards First Nations control in the health sector when their careers or employment status are clearly affected. Elsewhere in this document, reference is made to the differences that are often noted by our leaders between their interaction with Ministers and officials. Efforts are required to ensure continuity of effort throughout the government hierarchy. The actions of officials that subvert the collective will of our leaders and legislators by declaring policy voids or by deferring to restrictions imposed by Treasury Board will not be useful to effective collaborative relationships.

b) Identification of the capacity that is needed to sustain these new relationships as well as how to develop it.

- Mandated organizations and agencies will require the capacity for research, planning expertise, technical advice and consultation support to effectively support First Nations in the further development and implementation of the Blueprint. A Blueprint Manager and a modest Blueprint Secretariat operating under the direction of a steering mechanism established through a multi-jurisdictional agreement, is a model that should be considered. A Blueprint Secretariat should be staffed with contracted personnel and appropriate secondments or interchange agreements.
- All jurisdictions must have the capacity to implement change at operational levels, where it is most likely that change will have a direct impact on the communities that are served. This will mean the creation of a "forum" within the catchment area of

each of the Province's regional health authorities, with appropriate representation from interested parties and an implementation mandate. It should be left to the First Nations within each area to negotiate the shape and scale of each "forum" with the appropriate regional health authority. Support would be provided by the Blueprint Secretariat.

- In general, First Nations in British Columbia have not found the Ministry of Health's development of aboriginal health plans to have been a successful enterprise. The plans were made under the direction of the Ministry to the regional health authorities with planning imperatives and time frames imposed from the top. The participation of First Nations has, for the most part, been considered ineffective. Similarly, the regional efforts of FNIHB to engage First Nations in planning related to its programs and services have been driven by directives and templates imposed by Ottawa. There will be no structure within the collaborative relationships that are envisioned without proper plans. Similarly, the collective capacity of all the parties to the Blueprint will not be realized without a meaningful road map that leads to implementation and change. The first responsibility of a Blueprint Secretariat would be the creation of a viable planning process, fully supported by all parties and driven at the community level.

Conclusion

The First Nations of British Columbia do not have unrealistic expectations of this exercise. As noted at the beginning of this document, the Blueprint was developed in a short time frame without the fullness of participation and input that could have yielded a more comprehensive plan. Our expectations for change are further restrained by our understanding of the complexity of the issues and the depth of need of our people and families. A multitude of similar processes proceed this latest effort. The cynical view is that we have seen all of this before, these good intentions, this resolve to make meaningful change. This Blueprint, however, seeks to move forward and it seeks to trust the stated intentions of Canada and British Columbia for change that will make a difference in the lives of our communities through collaborative efforts. First Nations in British Columbia will participate in this collaboration with the guidance of our Elders, in the interest of our children, and with the vigilance of all our people over our combined efforts to implement the principles, ideas and actions contained in this Blueprint.