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## Developing a New First Nations Health Governance System: Creation of an Independent, First Nations Run Organization

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### A Provincial/Territorial Health Reform Analysis

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## Abstract

In 2011 a tripartite agreement between the province of British Columbia (BC), Health Canada, and First Nations leaders created the First Nations Health Authority (FNHA): a unique approach to First Nations health governance. The creation of the FNHA came after almost ten years of discussion and agreements between the three parties. The goal of the FNHA is to address health disparities between First Nations and other residents of BC, as well as increase the voice of First Nations people in the health system. The issues that led to the creation of the FNHA came onto the government's agenda due to an increased knowledge of the health crises facing BC First Nations, and a growing interest throughout Canada in increasing First Nations autonomy and input. In 2013 Health Canada transferred authority over all First Nations health programming to the FNHA, with the hope that an independent, First Nations run organization would better address the health-related needs of First Nations people. While evaluation of the FNHA is limited presently, since it released its first five-year plan just over a year ago, a 2015 report by the Auditor General gives some insight into how the FNHA is functioning. If the FNHA can overcome a few weaknesses and threats to its stability, it has the potential to guide First Nations self-determination with respect to health care in Canada.

*En 2011, une entente tripartite entre le gouvernement provincial de la Colombie-Britannique (C.-B.), Santé Canada, et les leaders des Premières Nations de la C.-B. a créé la First Nations Health Authority (FNHA) : une approche unique pour la gestion de la santé des Premières Nations. La FNHA a été créée après presque dix ans de discussion et accords entre les trois groupes. L'objectif de la FNHA est d'éliminer les disparités en matière de santé entre les Premières Nations et les autres résidents de la C.-B., et aussi d'augmenter la voix des Premières Nations dans le système de santé. Les questions qui ont mené à la création de la FNHA sont apparues sur l'agenda du gouvernement en raison d'une prise de conscience accrue des crises sanitaires auxquelles sont confrontées les Premières Nations de la C.-B. et un intérêt croissant pour l'autonomie et l'apport des Premières Nations. En 2013, Santé Canada a transféré l'autorité sur l'ensemble des programmes de santé des Premières Nations dans l'espoir qu'une organisation indépendante dirigée par les Premières Nations réponde mieux aux besoins des membres des Premières Nations. Alors que l'évaluation de la FNHA est limitée en ce moment, puisqu'elle a récemment publié son premier plan quinquennal, un rapport du vérificateur général de 2015 a donné un aperçu de la façon dont fonctionne la FNHA. Si la FNHA peut surmonter quelques faiblesses et doutes à sa stabilité, elle peut guider l'autodétermination des Premières Nations en matière de soins de santé au Canada.*

### Key Messages

- In 2011 a tripartite agreement between the province of British Columbia, Health Canada, and First Nations leaders created the First Nations Health Authority (FNHA).
- The FNHA is an independent, First Nations run organization that seeks to address the health related problems facing BC First Nations through increasing cultural respect and self-determination in health—i.e., the input that First Nations people have into their health care.
- In 2013 Health Canada transferred its authority over First Nations health programming to the FNHA.
- The FNHA has the potential to markedly reform the approach to First Nations health governance and other provinces may seek to emulate it. However, it still has to overcome administrative weaknesses and issues of recruitment and retention.

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### Messages-clé

- *En 2011 un accord entre la province de la Colombie-Britannique, Santé Canada, et les leaders des Premières Nations a créé la First Nations Health Authority (FNHA).*
- *La FNHA est une organisation indépendante dirigée par les leaders des Premières Nations. Elle cherche à aborder les problèmes de Santé auxquels sont confrontés les leaders des Premières Nations en renforçant le respect de la culture et l'autodétermination en matière de santé.*
- *En 2013 Santé Canada a transféré son autorité sur les programmes de santé des Premières Nations à la FNHA.*
- *La FNHA a la capacité de réformer l'approche des programmes de santé des Premières Nations et d'autres provinces peuvent aussi l'imiter. Cependant, il faut encore surmonter les faiblesses administratives et les problèmes de recrutement du personnel.*

# 1 BRIEF DESCRIPTION OF THE FIRST NATIONS HEALTH AUTHORITY AND THE AGREEMENT THAT MADE IT

In 2011 the Minister of Health for Canada, the Minister of Health for British Columbia (BC), and the First Nations Health Society signed the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (BCTFA on FNHG). The primary objective of this agreement was to restructure First Nations health governance, in order to improve First Nations health services and increase First Nations autonomy and input (*British Columbia Tripartite* 2011). The focal point of this restructuring was the creation of the First Nations Health Authority (FNHA), a unique non-profit legal entity that represents and is accountable to all First Nations people in the province of BC (*British Columbia Tripartite* 2011). The FNHA is responsible for, among other things, the planning, designing, managing, funding, and administering of First Nations health programs in BC (*British Columbia Tripartite* 2011).

With the creation of the FNHA, the BCTFA on FNHG also called for an interim health plan that would cover the years until the FNHA took full control over First Nations health programs (*British Columbia Tripartite* 2011). In 2013, Health Canada formally transferred its role in health programming to the FNHA. During the four years since then, the FNHA has made strides in a few areas, and the strengths and weaknesses of this unique approach to First Nations health governance are beginning to show.

## 2 HISTORY AND CONTEXT

Below is a brief timeline detailing the major events that led to the creation of the FNHA. It is important to understand that while the timeline covers a relatively brief period in Canadian history, less than forty years, the history that has led to the health issues faced by Indigenous communities in Canada is much longer. Colonization, the process of appropriating the land and resources of an area while establishing wrongful authority over the land's Indigenous population, has been ongoing in Canada since settlers first arrived. Over the years, colonization has been reinforced through a variety of instruments, such as the residential school system and the reservation system, which have led to serious physical and mental health problems in Indigenous communities (Brave Heart *et al.* 2011). Beyond that, Indigenous people in Canada also suffered centuries of devastation to their cultures, identities, and communities leading to intergenerational effects on health and well-being (Brave Heart *et al.* 2011). Any discussion of Indigenous health problems and care must therefore be situated in and understood from this context of ongoing colonialism.

- *September 1979*: The Federal government adopts the *Indian Health Policy*, which acknowledges the responsibility of the government, at both the provincial and federal levels, to provide health services to Indigenous people in Canada. It also recognizes

- the right of Indigenous communities to take over part or all of their community health programming (Health Canada 1999).
- *March 1988*: The Federal Government Cabinet implements the health transfer policy framework (known as the *Health Transfer Policy* or HTP). The HTP builds upon the *Indian Health Policy* by offering a specific process and framework through which all First Nations communities below the 60th parallel can gain control over their community health programming and the administration of health resources at the local level. This control could allow First Nations communities to design programs and allocate resources and funds in a way that meets their population's needs (Health Canada 1999).
  - *December 1997*: The BC provincial government adopts several health goals. Goal number five is "Improved health for Aboriginal peoples." This marks a full commitment by the province to monitor and improve Indigenous health (BC PHO 2002).
  - *October 2002*: The BC Provincial Health Officer (PHO) releases the *PHO's Annual Report (2001): The Health and Well-being of Aboriginal People in BC*, which seeks to evaluate the province's progress towards the goal of "Improved health for Aboriginal peoples." The report draws attention to a very large health disparity between Indigenous and Non-Indigenous people in BC. It also recommends taking a more holistic approach towards Indigenous health, and increasing the representation of Indigenous people in their health system (BC PHO 2002).
  - *December 2003*: Paul Martin becomes Prime Minister of Canada. He makes a commitment to take an inclusive approach to Indigenous issues (First Nations Summit 2005).
  - *September 2004*: Paul Martin holds a health conference between Indigenous leaders and the premiers of Canada, where he makes a promise to address the health disparity faced by Indigenous people within ten years (First Nations Summit 2005).
  - *April 2005*: The BC government and the First Nations Leadership Council (FNLC) agree to *The New Relationship*—a new way for the two groups to work together and increase input from First Nations leaders (Auditor General 2015).
  - *November 2005*: National Aboriginal leaders and First Ministers meet in Kelowna, BC for the First Ministers' Meeting on Aboriginal Issues. The parties commit to improving the lives of Indigenous people in Canada in an agreement that is later dubbed the Kelowna accord. At the same meeting the BC government, Canadian Government, and FNLC sign the *Transformative Change Accord* (TCA). This document is the first attempt at practically increasing BC First Nations input on their people's issues. It also highlights First Nations' health as a major area for improvement (*Transformative Change Accord* 2005).
  - *November 2006*: The FNLC and BC agree to the *Transformative Change Accord: First Nations Health Plan* (TCA:FNHP). It draws heavily from the *First Nations Health Blueprint*, a document submitted by the FNLC in 2005 outlining what the FNLC thought needed to change in the First Nations health sector (First Nations

- Summit 2005).
- *June 2007*: The FNLC, BC and Canada sign the Tripartite First Nations Health Plan (TFNHP). It broadly outlines a new health governance system intended to promote First Nations involvement, and calls for the creation of an autonomous body to run First Nations health programs (*Tripartite First Nations* 2007).
  - *October 2011*: The First Nations Health Society, BC, and Canada sign the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (BCTFA on FNHG), which established the First Nations Health Authority (FNHA) and other governing bodies. This agreement now supersedes the HTP in regards to the management of First Nations health programming in BC.
  - *October 2013*: Health Canada transfers its authority over First Nations health programming to the FNHA (*British Columbia Tripartite* 2011).

### 3 GOALS OF THE REFORM

The primary goal behind the creation of the FNHA was addressing the health disparities between First Nations and Non-Indigenous residents of BC. A secondary objective was to better incorporate culturally appropriate care, and the voice of First Nations people into the health care system (*British Columbia Tripartite* 2011). By establishing a new system of First Nations health governance the government of BC and Health Canada could also claim they had made a major step forward towards addressing the needs of First Nations. Additionally, the creation of the FNHA addressed the goal of many First Nations leaders to increase their overall self-determination.

### 4 FACTORS THAT INFLUENCED HOW AND WHY

#### 4.1 The issue came onto the government's agenda: problems, proposals and politics

Kingdon's framework provides a useful way to examine how problem, proposal, and political streams come together at critical times to create a "policy window" (Coffman 2007). According to this framework, the three streams operate largely independently, although two elements may overlap or come together before the third (Coffman 2007), as is the case with the creation of the FNHA.

The adoption of "Improved health for Aboriginal peoples" as a health goal by the provincial government in 1997 marked a formal recognition by the BC government of the seriousness of the health problems facing Indigenous communities in BC, and a commitment to monitor and address the problems (BC PHO 2002). PHO's 2001 annual report brought further attention to these issues, and laid out the steps the provincial government needed to take to address them (BC PHO 2002). Meanwhile, at the national level both First Nations

leaders and elected officials, such as Prime Minister Paul Martin, began to push for more attention to the problems facing Indigenous people (First Nations Summit 2005). Thus, in the political stream the actions of Paul Martin, as well as the provincial government's interest in addressing the health issues facing Indigenous communities, created a space to prioritize Indigenous health issues, and the BC First Nations leaders used their unified front to propel their requests to the forefront (First Nations Summit 2005). In 2005 the problem and political streams merged through the signing of the Transformative Change Accord, which marked a formal commitment by the provincial and federal governments to address the health disparity between First Nations and other BC Residents (Auditor General 2015). In total, the political strength of the First Nations leaders, and the desire of the provincial government to address Indigenous health problems, granted a somewhat unique opportunity not available to other Indigenous groups or First Nations in other provinces.

The combination of the problem and political streams are arguably what allowed the proposal stream to progress smoothly. Most notably, it enabled the *First Nations Health Blueprint for British Columbia*, proposed by the FNLC in 2005, to receive government recognition (First Nations Summit 2005). This led, in 2006, to the province and FNLC crafting the TCA:FNHP, which further developed First Nations health policy by prioritizing specific areas of improvement (Auditor General 2015). However, any policy agreements were limited without the involvement of the federal government, which oversees First Nations health. In June 2007 all three streams merged when the FNLC, BC, and Canada signed the TFNHP, and outlined a policy for creating a new First Nations health governance system and an independent First Nations run health organization (*Tripartite First Nations* 2007).

## 4.2 Interests, ideas, and institutions behind an independent health authority

The First Nations Health Blueprint shows that First Nations leaders thought they would benefit from a health governance system that, while interdependent with the government of Canada, would give them a greater degree of self-determination (First Nations Summit 2005). Meanwhile the federal and provincial governments were more and more concerned with taking an inclusive approach towards First Nations issues (First Nations Summit 2005). For some, though, the government's decision to proceed with a complete, and relatively quick, transfer of authority over First Nations health programming was surprising, given that similar transfers of authority in education and child protection in BC had met with mixed results and public disapproval of the emerging gaps in care and accountability (Hunter 2011). This suggests both levels of government may have felt a transfer of authority over health programming would reduce negative attention and shift some responsibility for the glaring health disparities, even if results from previous transfers of a similar level of authority did not necessarily support this plan.

The idea behind creating an interdependent and autonomous health system for BC First Nations people came from the *First Nations Health Blueprint* (First Nations Summit

2005). However, government officials also put forward ideas of increased autonomy, input, and cultural respect around the same time (First Nations Summit 2005; BC PHO 2002). These ideas fit with the government's interest in an inclusive approach that would reduce disapproval over how the government was handling the situation of Indigenous people.

At the institutional level, three legal cases (two First Nations versus BC Supreme Court cases in 2004, and a separate First Nations versus Canada case in 2005), clarified the government's responsibility to consult First Nations on government decisions (Auditor General 2015). At this time Health Canada already had a twenty-year legacy of transferring some authority over the delivery of health programming and the administration of health resources to individual First Nations, and the court cases helped further institutionalize the concept of increasing First Nations' voice and freedom (Auditor General 2015). These changes, combined with the stakeholders' interests and ideas of autonomy and input, led to the TFNHP in 2007, which called for the creation of what would eventually become the FNHA.

## 5 HOW THE REFORM WAS, AND WILL BE, ACHIEVED

The BCTFA on FNHG (*British Columbia Tripartite* 2011) declared that the FNHA would immediately begin negotiations with Canada, and conclude by 2013 the transfer of federal health programs. Included in the agreement was a list of federal health programs that would be part of the transfer, the majority of which applied only to on-reserve First Nations people, with the exception of the Non-Insured Health Benefits program which applies to all "Status Indians resident in BC" (*British Columbia Tripartite* 2011). In addition, the agreement stated that as the relationships between the FNHA, BC Ministry of Health, and BC Health Authorities strengthened, it was anticipated the FNHA would take on programming that benefits all First Nations, or even all Aboriginal, people in the province (*British Columbia Tripartite* 2011). The BCTFA on FNHG also outlined a plan for the interim period, before the transfer of health programs from Health Canada to the FNHA, and established transition teams to oversee the process (*British Columbia Tripartite* 2011). Moreover, the agreement set dates for evaluations of the implementation of the agreement, and set up both a one-time payment of up to \$17 million from the Canadian government, to help establish the FNHA, and a ten-year funding agreement (*British Columbia Tripartite* 2011).

In October 2013, the transfer of authority from Health Canada to the FNHA took place, and in 2014 the FNHA released its official service plan for the 2014-2015 year: the first full year of FNHA-provided services (*British Columbia Tripartite* 2011; FNHA 2014). The first priority outlined in the service plan was to stabilize the FNHA and create systems that would allow the FNHA to properly take control of certain aspects of health programming that were still under Health Canada's discretion (FNHA 2014). The other four goals laid out in the service plan were improving governance, health services, leadership/organization,

and partnerships with other First Nations entities (FNHA 2014). At this point the FNHA was still attempting to establish full control of health programming, and was trying to improve logistical aspects of the organization.

In the FNHA's next annual plan, for the 2015-2016 year, the goal of stabilizing the FNHA and providing a smooth transition was removed, as the FNHA began to move past this point (FNHA 2015). Included in this new plan was a commitment to produce the FNHA's first five-year multi-year plan (FNHA 2015). However, according to the initial tripartite agreement on First Nations health governance, the FNHA was supposed to produce the first multi-year plan once the transfers from Health Canada were substantially complete and the final interim health plan had expired (*British Columbia Tripartite* 2011). This suggests the creation of the FNHA was somewhat behind schedule, since the initial transfer of health programming took place in 2013, as anticipated, and the final interim plan expired in 2014.

The FNHA (2016a) finally released a set of five-year goals in its *2016-2017 Summary Service Plan*. The five-year goals were essentially the same four broad goals that were included in the previous service plans: strengthening First Nations health governance, operating as an "excellent First Nations health organization," supporting the BC First Nations approach to health and wellness, and improving their programs and services (FNHA 2016a, 16). However, this time the plan also outlined outcomes, annual key priorities, and measures for each goal, and elaborated on the purpose behind each goal (FNHA 2016a). While some of the annual key priorities were clearly defined and could be evaluated with relative ease, for example the creation of a "FNHA Data Quality and Identity Management Framework," others were less specific, such as "continue to implement improvements to the medical transportation component of health benefits" (FNHA 2016a, 28). Meanwhile many of the measures relied on client, participant, or partner "satisfaction" and the use of surveys (FNHA 2016a), which while potentially useful for analyzing the FNHA's progress over the next five years was also rather vague. In the 2017-2018 plan, the new set of annual key priorities also had various levels of specificity, while the quality of the proposed measures improved markedly through the inclusion of both a larger number and more specific measures (FNHA 2017). Overall the sequence of plans suggests the FNHA is beginning to make significant progress towards achieving and evaluating their goals.

## 6 EVALUATION

The BCTFA on FNHG stipulated that the FNHA would release annual reports detailing, among other things, the achievements and challenges from each year (*British Columbia Tripartite* 2011). These reports do provide limited evaluation of the impact the FNHA made in some areas, such as decreasing service times and increasing public health research (FNHA 2016b). However, the reports do not provide any critical evaluation of the FNHA. Some insight can be gained by comparing the FNHA's annual service plans, which, overall,

are improving in both scope and quality. While the creation of the first five-year plan was delayed, the FNHA now seems to be on track towards fulfilling its mandate, and the development of achievable and measurable outcomes and priorities suggests the FNHA is improving both its planning and evaluation capacity and First Nations health programming as a whole (FNHA 2016a; FNHA 2017). The most informative evaluation of the FNHA though will come at the end of the first five-year plan, which should coincide with the conclusion of the FNHA’s ten-year funding agreement with Canada and a serious evaluation of the FNHA’s progress.

In 2015, the Auditor General of Canada released a report from an audit conducted after an anonymous letter accused the FNHA of misogyny, bullying, improper hiring procedures, and a lack of accountability and transparency. The report identifies several success factors that allowed the FNHA to address major barriers to improving First Nations health outcomes (Auditor General 2015). It also states that the FNHA failed to develop proper accountability policies, and is not upholding its current policies on workplace misconduct and staffing key positions, such as management roles, with the most qualified applicants (Auditor General 2015). While this report offers some external evaluation of the FNHA, it is too early for a more in-depth evaluation of the FNHA’s successes and failures.

## 7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: Summary of potential strengths, weaknesses, opportunities, and threats of the FNHA

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>• Increases input of First Nations people into the governance of their health care</li> <li>• Greater focus on research into health related problems faced by First Nations people</li> <li>• Works within a collaborative health governance structure that includes Health Canada and BC</li> </ul>	<ul style="list-style-type: none"> <li>• Exclusion of other Indigenous groups, namely Métis and Inuit</li> <li>• A lengthy transition time may have delayed potential improvements.</li> <li>• The FNHA lacks control over major structural determinants of health such as access to food, water, and housing.</li> </ul>

OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>● Unique approach to First Nations health governance. If effective it could lead to changes throughout Canada.</li> <li>● Could better incorporate First Nations traditions, beliefs, and practices into health programs</li> <li>● Mobilize First Nations leaders' knowledge of their communities to improve the effectiveness of interventions</li> </ul>	<ul style="list-style-type: none"> <li>● Public disapproval of similar transfers of authority in education and child protection (Hunter 2011)</li> <li>● Lack of accountability and transparency threaten internal stability (Auditor General 2015)</li> <li>● Limitations in the FNHA's Recruitment and Selection policy are jeopardizing the organization's ability to recruit the most qualified applicants for manager positions (Auditor General 2015).</li> </ul>

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