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# Toward a New Era of Policy: Health Care Service Delivery to First Nations

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# Toward a New Era of Policy: Health Care Service Delivery to First Nations

**Abstract**
The disproportionate burdens of ill health experienced by First Nations have been attributed to an uncoordinated, fragmented health care system. This system is rooted in public policies that have created jurisdictional gaps and a long-standing debate between federal, provincial and First Nations governments as to who is responsible for First Nations health care. This article examines: (1) the policies that shape First Nations health care in Canada and in the province of British Columbia (BC) specifically; (2) the interests of the actors involved in First Nations health policy; and (3) recent developments in BC that present an opportunity for change to First Nations health policy development and have broader implications for Indigenous health policy across Canada and worldwide.

**Keywords**
First Nations, health policy

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## Introduction

Aboriginal Peoples in Canada are disproportionately burdened with ill health as compared to other Canadians (Waldram, Herring, & Young, 2006). The high rates of morbidity and mortality among Aboriginal Peoples have been attributed in part to an uncoordinated, fragmented system of health care service delivery. This system is rooted in public policies that have created jurisdictional gaps such that a longstanding debate continues between federal, provincial and Aboriginal governments as to who is responsible for the delivery of health care to Aboriginal Peoples (Jacklin & Warry, 2004; Pierre, Pollack, & Fafard, 2007; Lavoie & Forget, 2008; British Columbia Provincial Health Officer, 2009). While First Nations, Inuit and Métis are collectively recognized as Aboriginal under the Canadian Constitution Act of 1982, policies are not applied consistently across the three groups and therefore, each group faces its own unique set of challenges in navigating the Canadian health care system. This article will examine the policies that have and continue to shape First Nations health care service delivery in Canada, and in the province of British Columbia (BC) specifically. Next, the interests of the actors involved in First Nations health policy will be examined. Finally, recent developments in the province of BC will be examined as an opportunity for change in the process of First Nations health policy development.

Currently, the federal government accepts responsibility of delivering primary health care services on-reserve, as well as providing funding to the province for cost-shareable programs, contracted services, and health care premiums (in provinces that charge premiums) for Status Indians (Lavoie & Forget, 2008; British Columbia Provincial Health Officer, 2009). The province, meanwhile, is responsible for primary health care services off-reserve, as well as hospital and physician services. While these jurisdictional boundaries may be clear in theory, they have proven to be ambiguous and complex in practice, suggesting a need to revisit the policies that have shaped this current system of health care delivery.

Policies regarding First Nations have previously been analyzed as occurring in discrete waves, or, eras. Lavoie, Forget and Browne (2010) described these policies as occurring in four waves: (1) early institutionalized contact policies (pre-1860); (2) post-confederation protective paternalistic policies (1860-1920); (3) assimilative paternalistic policies (1920-1960); and (4) policies that respect cultural identity and political autonomy (1960 – present). For a large part of Canadian history, the goal of First Nations policy was assimilation. Policies that emerged under the assimilation paradigm developed through a "process that heard no Aboriginal voices and did not wish to" (Cairns, 2000, p. 95). In this article, policies are described as occurring in two eras: policies of assimilation and policies of recognition. The intent of examining policies in terms of these two eras is to highlight the key policies that have and continue to shape First Nations health care service delivery, and to guide the reader through the gradual shifts in policy-making that bring us to our current state of affairs.

## Policies of Assimilation

While this author recognizes 'First Nations' and 'Aboriginal' to be preferred terms for use in contemporary Canada, the term 'Indian' is used here to remain consistent with the terminology used at the time of policy development.

### Historic Treaties (1871 – 1921)

Between 1871 and 1921, the Crown signed treaties with some First Nations wherein the First Nations gave up areas of land to the Crown in exchange for reserve lands, annual payments, fishing and

hunting rights, schools and educational resources, farm equipment and animals, and other material goods. While treaties were settled in Northern Ontario, Manitoba, Saskatchewan and Alberta, only parts of BC were settled by treaty. It is also noteworthy that only one treaty (Treaty No. 6 between the Crown and the Plains Cree) included from the Crown "the promise of a medicine chest", which has been interpreted by some to be a promise for provision of health care (Indian Affairs and Northern Canada, 2010).

### British North America Act (1867)

The British North America Act defined Indian affairs as a federal jurisdiction and health care as a provincial jurisdiction. This division has served as a starting point to the debate regarding jurisdiction of Indian health care (Lavoie & Forget, 2008; Lavoie, Forget, & Browne, 2010).

### Indian Act (1876)

The Indian Act has two major influences on the delivery of health care services to First Nations. First, the Indian Act dictates who is an Indian. By way of assigning "Status", the Indian Act is a tool that the federal government has used to determine who is considered an Indian and who, therefore, is a federal responsibility. Second, the Indian Act established reserves. The reserve system is another mechanism used to define federal jurisdictional boundaries, as the federal government restricts its responsibility for health care provision to "on-reserve".

### The White Paper (1969) and the Red Paper (1970)

The federal government's 1969 White Paper proposed the removal of Status under the Indian Act and the special services that came with Status as a means to increase the assimilation of Indians into the rest of society (Health Canada, 2005). It is notable that while Indian leaders were consulted during development of the White Paper, their input was not included in the final product, thereby contributing to the strong opposition that the White Paper aroused from Indian Peoples (Cairns, 2000). The official Indian response to the White Paper was the Red Paper of 1970, which emphasized federal responsibility for health care to Indians and the desire to strengthen community control of health programs. The White and Red Papers were key developments that pushed federal policies into a new era, putting "an official end to what had been the basic policy of the Canadian state from its inception… the goal of assimilation" (Cairns, 2000, p. 51). With the end of the goal of assimilation came the next era of policy: policies designed to recognize Indian culture and rights to control health programs.

## Policies of Recognition

### Indian Health Policy (1979)

In recognition of the poor health outcomes among Indians and the need for Indians themselves to participate in change, the federal government's Indian Health Policy was designed with the goal to "achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves" (First Nations Inuit Health Branch, 2007). This policy is significant in that the

federal government acknowledged its roles to be to advocate on behalf of Indians to the larger Canadian society, promote capacities of Indian communities, and provide public health and health promotion activities on-reserve. The role of the provinces is identified to include diagnosis and treatment of illness and rehabilitation. The role of Indian communities is emphasized: to play a role in health promotion and in the administration of community health programs.

**Canada Health Act (1984)**

The Canada Health Act (CHA), which established national standards for health care service delivery, does not explicitly address the issue of First Nations health care jurisdiction. Persons insured under the CHA (and therefore within provincial jurisdiction) are defined as residents of the province other than members of the Canadian Forces or Royal Canadian Mounted Police, federal inmates, or residents of the province who have not completed a minimum period of residence (Department of Justice, 2010). The coverage of Status and/or Treaty Indians is not stated, although MacIntosh (2008) has argued that under the CHA, "provinces have agreed to deliver insured health services to all persons normally resident in the province, which includes Aboriginal residents regardless of whether they live on or off reserve" (p. 86).

**Indian Health Transfer Policy (1989)**

The Indian Health Transfer Policy is an offer by the federal government to First Nations communities south of the 60$^{th}$ parallel to transfer resources for health programs over to control by the community (Health Canada, 2005). The transfer occurs in gradual phases, requires specific mandatory public health programs to be provided, gives communities flexibility to allocate funds according to community priorities, and limits funding, by way of a non-enrichment clause, to health care delivery costs at the time of transfer (MacIntosh, 2008). The Indian Health Transfer Policy, as a follow-up to the Indian Health Policy of 1979, was the next step toward increasing the involvement of Indian communities themselves in the delivery of health care services.

**Royal Commission on Aboriginal Peoples (1991 - 1996)**

A royal commission is an instrument used in Canada to charter a new path for the future and to draw recognition to a critical national issue. Commissioned in 1991, the Royal Commission on Aboriginal Peoples (RCAP) was tasked with addressing issues of Aboriginal Peoples, including their recognition, status, and future prospects. The final RCAP report, published in 1996, consisted of five volumes and over 4,000 pages that called for a new relationship between Aboriginal and non-Aboriginal people and the provincial, territorial, and federal governments. The report's recommendations addressed a scope of issues, including housing, child welfare, education, and health. Although the federal government has not implemented the RCAP recommendations, the RCAP has arguably succeeded in gaining recognition of Aboriginal issues in Canada. As Cairns (2000) stated, "The mere existence of RCAP… signaled a paradigm breakdown in the Aboriginal/non-Aboriginal relationships, and the search for a more positive successor paradigm" (p. 19), that is, a new relationship.

The above description of key policies influencing First Nations health service delivery has provided some indication of the various actors involved in shaping First Nations health policy. However, it would be useful at this point to take a more in-depth look at the interests of the actors involved.

## Interests of the Actors

The goals of the policies described above gradually shifted from assimilative to supportive of First Nations control and autonomy. However, the more recent policies that were designed to support transfer of resources and control over to First Nations communities were not universally embraced. Some communities and scholars were suspicious of the motivations behind the policies, and wondered if the federal government was acting in its own best interest rather than that of the First Nations (Jacklin & Warry, 2004; MacIntosh, 2008). In the following section, the interests of four separate actors will be examined: the federal government; the provincial government of BC; the general public; and First Nations.

### Federal Government

It is important to understand that throughout the eras of policy development, the federal government has never acknowledged a legal obligation to provide health care services to First Nations. Rather, the federal government's stance is that it has a special relationship with First Nations, which it is committed to preserving (First Nations Inuit Health Branch, 2007) and that its provision of health services on-reserve is a matter of goodwill (British Columbia Provincial Health Officer, 2009). Some have argued that the federal government has provided care for socio-political and economic reasons, as well as practical reasons, such as to prevent spread of disease to the non-Aboriginal population and to serve isolated and remote communities (Jacklin & Warry, 2004; Lavoie et al., 2010).

However, Lavoie et al. (2010) have argued that in recent years, the federal government has actively sought to distance itself from health care service provision by way of transferring responsibility to the provinces and First Nations under the guise of supporting community control and autonomy (Lavoie et al., 2010). Indeed, the suspicion with which some communities regarded the Indian Health Transfer Policy has not gone unfounded. Evaluations of the health transfers have shown significant cost-shifting to First Nations with limited benefits at the community-level (Jacklin & Warry, 2004; Lavoie et al., 2010).

Another mechanism by which the federal government can shift the costs of health care service delivery over to the provinces and First Nations is through its "closely guarded" (Lavoie et al., 2010, p. 86) construction of who is an Indian. Through amendments to the Indian Act (e.g. Bill C-31 and Bill C-3), the federal government can extend or restrict eligibility for Indian Status. Restricting eligibility for Indian Status results in a larger number of non-Status First Nations persons who fall under provincial jurisdiction for health care services. Conversely, extending eligibility for Status increases the number of Status Indians that fall under federal jurisdiction, but the increased population size of persons entitled to access services on-reserve has typically not been accompanied with increased federal budgets for community services, thereby shifting costs to the community itself (Lavoie et al., 2010). Frustrations with the federal government's reluctance to increase its financing of First Nations health care services were further fueled when Stephen Harper's Conservative government, elected in 2006, would not commit to investing $5 billion into Aboriginal health care – a promise made by Paul Martin's Liberal government in the 2005 Kelowna Accord (Pierre et al., 2007). Overall, financial motivations appear to play a key role in how the federal government interprets and develops First Nations health policy.

Of course, one should not overlook the influence of the global political climate on the policy decisions of the Canadian federal government. For example, the desire to gain credibility and avoid criticism from the United Nations (UN) factored into Canada's extension of voting rights to Indians in 1960 and the 1969 White Paper's proposal to abolish Indian Status (Cairns, 2000). In 2007, Canada voted against the UN Declaration on the Rights of Indigenous Peoples, citing concerns that the Declaration was

inconsistent with the Canadian Constitution Act of 1982 and the Canadian Charter of Rights and Freedoms (Indian and Northern Affairs Canada, 2009); however, in 2010, Canada officially endorsed the Declaration and reaffirmed the nation's "commitment to promoting and protecting the rights of Indigenous peoples at home and abroad" (Indian and Northern Affairs Canada, 2010). Moving forward, international pressures will likely continue to shape the federal government's position on public policy and First Nations health.

Regardless of the underlying reasoning, "the federal government continues to promote First Nations-controlled health services as the preferred mechanism for alleviating the health inequalities" faced by First Nations communities (Lavoie et al., 2010, p. 84).

**Provincial Government of BC**

The Provincial Government of BC, like the federal government, has interests that underlie how First Nations policy is shaped. In BC, the Ministry of Aboriginal Relations and Reconciliation is the primary agency that deals with First Nations policy. The Ministry negotiates treaties and other agreements, and cites its reasons for these negotiations to be moral, economic, constitutional and legal (Ministry of Aboriginal Relations and Reconciliation, n.d.). The provincial government acknowledges that policies need to support improving quality of life of First Nations and create economic opportunities for First Nations. As far as constitutional and legal reasons, the Ministry of Aboriginal Relations and Reconciliation states, "the courts have told government repeatedly that Aboriginal rights and title exist, and that these rights have significant impact on the way government does its business" (Ministry of Aboriginal Relations and Reconciliation, n.d.), suggesting that the provincial government may wish to avoid legal troubles and engage in First Nations policy development in a more inclusive way.

With regards to health, the Government of BC supports full participation of First Nations in the design, delivery and evaluation of health care services (British Columbia Provincial Health Officer, 2009). Through its Ministry of Health Services, the province "provides stewardship and expertise to help close the gap in health status" between First Nations and non-First Nations British Columbians (Ministry of Health Services, n.d.). The province continues to work toward establishing provincial and regional targets for the health status of First Nations in BC, hold ministries and health authorities accountable for progress toward those targets, and support efforts of First Nations to achieve self-determination and sense of control over health (British Columbia Provincial Health Officer, 2009).

**General Public**

Some of the Canadian public is wary of or resistant to the idea of Aboriginal autonomy in health care, or any self-governance for that matter. These feelings are often based on the belief that First Nations do not deserve preferential services or entitlements based on ethnicity (Lavoie et al., 2010). The interests of voters are important to the federal and provincial governments; therefore, both levels of government have worked toward raising public awareness of health issues among First Nations (e.g., the federal government's 2008 apology to former students of the Indian residential schools), and the need for unique solutions to address these issues.

**First Nations**

First Nations have long sought public awareness of health disparities and advocated for greater autonomy in health care governance. The stated goal of the Assembly of First Nations' Health and Social Secretariat, for example, is to achieve "First Nations' control of the development and delivery of all health and social services, and programs" (Assembly of First Nations Health and Social Secretariat, n.d.). While more than half of First Nations in BC have achieved some level of management of their own health services on-reserve through the Indian Health Transfer Policy (British Columbia Provincial Health Officer, 2009), there remains considerable variation in the degree of funding, autonomy, and provision of quality health care services. The Indian Act has also imposed divisions between First Nations (e.g., Status vs. non-Status, on-reserve vs. off-reserve, and provincial and national borders) that have increased inequities between First Nations persons. Therefore, First Nations are concerned not only about the disparities between First Nations and the general population, but the disparities between First Nations. To address these inequities, First Nations need more than participation in and control over the design, delivery, and evaluation of health care services. They also require meaningful participation in policy development and decision-making.

It is evident that the interests of the key actors presented above have not only shaped First Nations health policy, but also the relationships between actors. As described earlier in this article, by the late 1990s, with the publication of the RCAP report, there was a call for a new relationship between First Nations and the federal and provincial governments. In the following section, developments toward a new relationship in BC will be examined.

## A New Era Of Policy

While policies toward community-control and self-determination have made progress toward improving health care service delivery to First Nations, they have not yet been sufficient to eliminate the disparities of health between First Nations and between First Nations and the general population. As MacIntosh (2008) has argued:

> …changing who is planning and delivering programs … is unlikely to engender improvements, either because the problem is one which plagues the health care system generally, or because the problem requires a comprehensive response which is beyond the authority or resources of most First Nations. (p. 73)

To date, health care service delivery to First Nations has been narrowly defined by the jurisdictions, priorities, and mandates of the provincial and federal governments while the need for an overall efficient system has been largely overlooked (Lavoie & Forget, 2008). Lavoie and Forget (2008) have recognized that, "gains will be realized only if we look for improving efficiency in the system as a whole, and with the establishment of cross-jurisdictional cooperative processes of planning and decision-making" (p. 119).

The RCAP report's call for a new relationship between the federal government and Aboriginal and non-Aboriginal Canadians has not gone ignored. On June 11, 2008, Stephen Harper's federal government made a historic apology to survivors of the Indian residential school system. In his apology, Harper acknowledged that "policy of assimilation was wrong, has caused great harm, and has no place in our country" (Harper, 2008). As a step toward healing, the federal government has also established the Indian Residential Schools Truth and Reconciliation Commission (TRC). The TRC can be seen as:

> … a positive step in forging a new relationship between Aboriginal peoples and other Canadians, a relationship based on the knowledge of our shared history, a respect for each other and a desire to move forward together with a renewed understanding that strong families, strong communities and vibrant cultures and traditions will contribute to a stronger Canada for all of us. (Harper, 2008)

As part of this renewed relationship should come a new process of policy development, based not on the assimilative goals of the past, but on today's goal of mutual respect and understanding.

**The New Relationship in BC**

An exciting example of a new relationship is currently underway in BC. Since 2005, significant steps have been taken toward improving relations and coordination between First Nations in BC and the provincial and federal governments. In March of 2005, a Leadership Accord was signed between the First Nations Summit, Union of BC Indian Chiefs, and BC Assembly of First Nations to formalize a cooperative working relationship between the parties to represent First Nations of BC (First Nations Summit, Union of British Columbia Indian Chiefs, BC Assembly of First Nations, 2005). Executives of the parties form the First Nations Leadership Council (FNLC). One goal of the FNLC is to work toward policy change that will benefit all First Nations. Toward this goal, the FNLC and the Province of BC agreed in April of 2005 to "a new government-to-government relationship based on respect, recognition and accommodation of aboriginal title and rights" (First Nations Leadership Council, Government of BC, 2005). Then, in November of 2005, the FNLC signed the *Transformative Change Accord* (TCA) with the Province of BC and the Government of Canada, thereby marking the beginning of a revolutionary collaborative and coordinated cross-jurisdictional partnership with the intent to make First Nations "full partners in the success and opportunity of the province" (Government of British Columbia, Government of Canada, and First Nations Leadership Council, 2005).

Health has been a top priority throughout the development of this new relationship. In the document entitled, *First Nations Health Blueprint for British Columbia*, the FNLC (2005) envisioned a "*distinct* yet *interdependent* health system" (p. 2) for First Nations, wherein First Nations and the governments of BC and Canada work in partnership in the development of public policy aimed at improving First Nations health, and "are equal partners in the process" (p. 2). The blueprint emphasizes the need for balance in government-to-government relationships, particularly with respect to First Nations participation in governance, decision-making, policy-making (including the legislative process), planning, and delivery and evaluation of health services. Also in 2005, the TCA identified health as one of the key areas for action (Government of British Columbia, Government of Canada, and First Nations Leadership Council, 2005). This landmark accord was followed by the *Transformative Change Accord: First Nations Health Plan* (TCA:FNHP) (First Nations Leadership Council and Province of BC, 2006) and the *First Nations Health Plan: Memorandum of Understanding* (MOU) (First Nations Leadership Council, Government of Canada, and Government of British Columbia, 2006), both in 2006. The MOU acknowledges that "maintaining the status quo will not close the health gaps between First Nations and British Columbians" and reiterates the importance of collaborative and coordinated partnership between First Nations, BC and Canada for improving health of First Nations. The MOU identifies four areas for collaboration: (1) governance, relationships and accountability; (2) health promotion and disease and injury prevention; (3) health services; and (4) performance tracking. The TCA:FNHP builds on the TCA and the *First Nations Health Blueprint for British Columbia*, proposing 29 actions required in the four key areas for collaboration. Some of the noteworthy action items include establishing a First Nations Health Council to advocate for First Nations with respect to health issues and to provide leadership in the implementation of the TCA:FNHP (the First Nations Health Council was established in

February of 2007); appointing a first-ever Aboriginal Physician Advisor to the Provincial Health Officer to advise on Aboriginal health issues (Dr. Evan Adams was appointed Aboriginal Physician Advisor in April of 2007); and establishing a First Nations Health Advisory Committee to monitor the regional health authorities Aboriginal Health and Wellness Plans and to provide advice to the parties on closing health gaps (this committee first met in September of 2007, and later became the Provincial Committee on First Nations Health). In June of 2007, the Tripartite partners signed the *Tripartite First Nations Health Plan* (TFNHP), which is a 10-year plan that builds on the MOU and TCA:FNHP (First Nations Leadership Council, Government of Canada, and Government of British Columbia, 2007). The TFNHP introduced two important new actions: (1) to form a First Nations Health Governing Body (now designated to be a First Nations Health Authority) to take over the management and direction of the services currently provided by the First Nations and Inuit Health BC Regional Office; and (2) to form an Association of Health Directors to provide voice to health professionals working in First Nations (this association was formed in April of 2010). A central component of the TCA:FNHP is the development and implementation of a new governance system for health services for First Nations.

The development of the new governance system is an ongoing process. Currently, the plan for implementation of the new health administrative arrangement is based on four components: the First Nations Health Council (FNHC), the First Nations Health Directors Association (FNHDA), the Provincial Committee on First Nations Health, and the First Nations Health Authority (FNHA). This structure is further described in the 2010 document, *Basis for a Framework Agreement on Health Governance* (First Nations Health Council, Government of Canada, Government of British Columbia, 2010). One of the principle intentions of the basis for a framework agreement is to "Provide for the transfer of the policy and service delivery role currently undertaken by the Federal Government to BC First Nations" (First Nations Health Council, Government of Canada, Government of British Columbia, 2010, p. 6). While this document is a non-legal agreement, it forms the basis for a legal framework agreement between First Nations and the governments of BC and Canada. So far, implementation of the Tripartite health plan has not been without challenges, as will be described below (First Nations Health Council, 2010).

When the FNHC was formed in 2007, its primary roles were: (1) to support First Nations in achieving health priorities, objectives and initiatives; (2) to participate in federal and provincial government health policy and program planning processes; and (3) to provide leadership in the implementation of the TFNHP (First Nations Leadership Council, Government of Canada, and Government of British Columbia, 2007). The FNHC membership reflected that of the FNLC in that it was composed of politically appointed representatives. In the interim, the First Nations Summit acted as the administrative host agency, which included managing finances and entering into legal agreements. However, as the new governance system developed and the workload increased substantially in volume, there was need for this structure to evolve. The First Nations Health Society was formed in 2009 to act as the corporate governance and operational arm for the FNHC, thereby relieving the First Nations Summit of its interim administrative duties and the associated legal and financial risks. In March of 2010, the Union of BC Indian Chiefs passed a resolution calling for the restructuring of the FNHC to replace the politically appointed representatives with three regional representatives from each of the five regions in the province. This resulted in a regionally appointed FNHC for a two-year term (2010-2012). The new structure of the FNHC has served to put some separation between political and health priorities, and will provide more direct reporting and accountability to regions and First Nations.

The FNHC has been tasked with supporting BC First Nations in achieving health priorities, objectives and initiatives. This requires extensive community collaboration and communication, which is no easy task given the diversity and geographic span of the 203 First Nations across the province. The FNHC has found a number of avenues to overcome this challenge, which includes forming regional caucuses and community engagement hubs, and holding annual community engagement forums (first held in 2007) (First Nations Health Council, 2010). The FNHDA will also support community collaboration

and communication, by representing health professionals working in First Nations and advising the FNHC.

Funding has also been a challenge. The cost of implementing the 29 action items in the TCA:FNHP was estimated to be $24 million, yet at the time that partners signed the TFNHP there was no agreement established for providing funds to cover these costs (First Nations Health Council, 2010). The FNHC reached a four-year funding agreement with the Government of Canada by 2007-2008, and in the recent *Basis for a Framework Agreement on Health Governance*, it is agreed that the federal government will negotiate a 10-year funding agreement (First Nations Health Council, Government of Canada, Government of British Columbia, 2010). However, federal funding has been inconsistent, with delivery of funds being delayed by one or two fiscal years (First Nations Health Council, 2010). In 2009-2010, after strong advocacy from the FNHC, the Government of BC committed to a 10-year agreement of $83.5 million to implement the TFNHP. Long term funding is key to the success of this endeavor for, as the FNHC (2010) states, the partners "do not want to fall into the trap of making immediate short-term decisions due to financial constraints" (p. 97).

Possibly the greatest challenge to the Tripartite partnership and the development of a new health governance system is that this process has never been implemented before in Canada (First Nations Health Council, 2010). There is no existing model for this kind of partnership or governance structure. The provincial and federal governments were not designed for this type of partnership, and the large bureaucratic structures of the provincial and federal partner organizations could easily overshadow the FNHC and its technical team. As described in *Our Story – A three year progress report 2007-2010*, "For the FNHC, the TFNHP is the number one priority. For the Tripartite partners, the TFNHP is one of many priorities" (First Nations Health Council, 2010, p. 95). Problems have been encountered in communicating roles and responsibilities, learning jargon and structure of government ministries and health authorities, identifying counterparts in partner organizations, bringing decision-makers to the table, and raising awareness of First Nations perspectives. The partnership must also endure restructuring of partner organizations, for example, the 2008 split of the BC Ministry of Health into the Ministry of Health Services and Ministry of Healthy Living and Sport, and the subsequent merging of the these two ministries in October of 2010. In addition, Tripartite partners have struggled to draw on First Nations expertise while not draining resources away from communities. Overall, significant time has been invested in engaging partners to establish effective communication and collaboration, and this remains an ongoing challenge.

Despite these challenges, the Tripartite partners have remained committed to establishing a new model of cross-jurisdictional cooperation in First Nations health governance. A key component of the new governance structure is the meaningful participation of First Nations in policy and decision-making. To avoid repeating the mistakes of the past, First Nations need to be involved in health policy development. Only then will we have forged the new relationship that was envisioned in the RCAP report and the 2008 apology to survivors of residential schools. The Tripartite partners recognize the importance of First Nations involvement in health policy:

> The Parties recognize that the transfer of health policy and program responsibilities to BC First Nations would facilitate the development of holistic and better integrated programs that could improve necessary linkages in education, child and family, housing, etc. This would have the dual benefit of improving health services and facilitating action on the social determinants of health. (First Nations Health Council, Government of Canada, Government of British Columbia, 2010, p. 8)

Although the process is still underway, the development of a new First Nations health governance system in BC presents an exciting opportunity for change in the way First Nations health policy is

developed and implemented. The "New Relationship" in BC could launch a new era of First Nations health policy – an era when policy is not made *for* First Nations, but *by* First Nations.

## Conclusion

The disproportionate burdens of ill health experienced by First Nations have been attributed in part to an uncoordinated, fragmented system of health care service delivery. This system is rooted in a series of key public policies that have created jurisdictional gaps and a long-standing debate between federal, provincial and First Nations governments as to who is responsible for the delivery of health care to First Nations. Throughout Canadian history, policies have gradually shifted from assimilative to supportive of First Nations control and autonomy. However, simply increasing First Nations control and autonomy in health care programming has not proven sufficient for closing the gaps in health between First Nations and the general population.

Recent developments in BC are shifting toward a collaborative and coordinated partnership across jurisdictions for the improvement of health of First Nations in the province. The inclusion of First Nations as equal partners in this Tripartite process may set a new standard for health care service delivery, not just within the province of BC, but across Canada and for Indigenous peoples worldwide. With the prospect of First Nations in BC fully engaging in policy development with their provincial and federal partners, it suggests that perhaps a new era of First Nations health policy is upon us; an era of moving forward together.

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