BRITISH COLUMBIA TRIPARTITE FRAMEWORK AGREEMENT ON FIRST NATION HEALTH GOVERNANCE

Made as of the 13th day of October, 2011

Between

HER MAJESTY THE QUEEN IN RIGHT OF CANADA
as represented by the Minister of Health

and

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA
as represented by the Minister of Health

and

FIRST NATIONS HEALTH SOCIETY

Endorsed by

FIRST NATIONS HEALTH COUNCIL

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RECITALS

Whereas:

A. The Parties wish to build on the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) and the *Tripartite First Nations Health Plan* (2007) to help improve the health and well-being of First Nations people in British Columbia;

B. The provisions of this Agreement have been guided by the principles established in the document entitled *British Columbia Tripartite First Nations Health – Basis for a Framework Agreement on Health Governance* (2010);

C. The Parties have agreed to develop a *Health Partnership Accord* that will capture the vision of the Parties for a better, more responsive and integrated health system for First Nations in British Columbia and will build on the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) and the *Tripartite First Nations Health Plan* (2007). The *Health Partnership Accord* will be a non-binding document that will describe the broad and enduring relationship amongst the Parties and their political commitment to pursue their shared vision. It is intended that the Health Partnership Accord will become an evergreen

document that keeps pace with changing circumstances respecting First Nations' health and with the evolving nature of the partnership among the Parties;

D. British Columbia funds, administers and delivers health care services to all residents of British Columbia, including Status Indians, guided by the provisions of the *Canada Health Act* (Canada). Health care services include primary care and care in hospitals as provided for under the BC *Medicare Protection Act* and the BC *Hospital Insurance Act*;

E. Canada funds or provides a range of community-based health programs and services and non-insured health benefits to First Nations and Inuit residents of British Columbia;

F. The First Nations Health Council (FNHC) is an unincorporated organization that has a mandate, *inter alia*, to act as an advocate for BC First Nations in health related matters, to implement the commitments in the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) and the *Tripartite First Nations Health Plan* (2007) and, by way of resolutions of the First Nations Summit in assembly and the Union of British Columbia Indian Chiefs, to oversee negotiations for this Agreement on behalf of BC First Nations;

G. The First Nations Health Society (FNHS), is a society with a mandate, *inter alia*, to promote and advance health and health service issues on behalf of First Nations in British Columbia, to implement the commitments in the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) and the *Tripartite First Nations Health Plan* (2007);

H. BC First Nations wish to be fully involved in decision-making regarding the health of their people, and how health services and programs are planned, designed, managed and delivered to better serve their needs;

I. The Parties wish to work together to build:

(1) a new Health Governance Structure that avoids the creation of separate and parallel First Nation and non-First Nation health systems and in which First Nations will plan, design, manage and deliver certain health programs and services in British Columbia and undertake other health and wellness-related functions;

(2) a more integrated health system:

- with stronger linkages among the FNHA, First Nation Health Providers, Health Canada, the BC Ministry of Health and BC Health Authorities, to better coordinate the planning, design, management and delivery of FN Health Programs so as to improve the quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations;

- that reflects the cultures and perspectives of BC First Nations and incorporates First Nations' models of wellness;

- that embraces knowledge and facilitates discussions in respect of determinants of health in order to contribute to the design of First Nation health programs and services;

- in which First Nations in all regions of British Columbia will have access to quality health services at a minimum comparable to those available to other Canadians living in similar geographic locations.

NOW THEREFORE in consideration of the mutual covenants and agreements herein contained and other good and valuable consideration, the receipt and sufficiency of which the Parties hereby acknowledge, the Parties agree as follows:

SECTION 1 – DEFINITIONS

1.1 Definitions

In this Agreement, unless the context requires otherwise:

(1) ***Agreement*** means this agreement including any schedules to this agreement, as amended from time to time.

(2) ***Annual Federal Amount*** has the meaning given in section CF 3 of Schedule 1.

(3) ***Annual Report*** means a document to be prepared by the FNHA as set out in section 5.4.

(4) ***BC First Nation*** means: (i) a "band" within the meaning of the *Indian Act* (Canada) in British Columbia and (ii) any Self-Governing First Nation, and the plural term ***BC First Nations*** refers to all or a number of such bands or Self-Governing First Nations as the context requires.

(5) ***BC Health Authority*** means a board established under the BC *Health Authorities Act* or the regulations thereto, as amended, and the Provincial Health Services Authority established under the BC *Society Act.*

(6) ***British Columbia*** means Her Majesty the Queen in right of the Province of British Columbia, as represented by the Minister of Health.

(7) ***Canada*** means Her Majesty the Queen in Right of Canada, as represented by the Minister of Health.

(8) ***Canada CA*** means a contribution agreement between Canada and a First Nation Health Provider in British Columbia.

(9) ***Canada Funding Agreement*** means the ten (10) year funding agreement as more particularly described in Part 1 of Schedule 1 (Canada Funding Schedule) which may be entered into at once or in stages for all or part of the Annual Federal Amount.

(10) ***FNHA*** means the First Nations Health Authority, a non-profit legal entity to be established with the process, powers and mandate set out in s. 4.2.

(11) ***FNHC*** means the First Nations Health Council, an unincorporated association described in section 4.4.

(12) ***FNHDA*** means the First Nations Health Directors Association, a society under the BC *Society Act*, described in section 4.5.

(13) ***FNHS*** means the First Nations Health Society, a society under the BC *Society Act* described in recital G.

(14) ***FN Health Programs*** means the health programs and services or benefits and related activities that the FNHA plans, designs, manages and delivers or funds the delivery of pursuant to this Agreement.

(15) ***Federal Health Programs*** means the health programs, services or benefits and related activities that are currently funded or delivered by Health Canada in British Columbia through the HC/FNIH Regional Office and set out in Schedule 3.

(16) ***First Nations Community Health and Wellness Plan*** means a plan developed by First Nation Health Providers pursuant to funding arrangements with the FNHA.

(17) ***First Nation Health Provider*** means any Indian band, Self-Governing First Nation, tribal council, First Nation organization or other person that is funded by the FNHA to provide FN Health Programs.

(18) ***HC/FNIH Regional Office*** means those parts of the Regions and Programs Branch of Health Canada (BC Region) which undertake the planning, design, management and delivery of certain Federal Health Programs.

(19) ***HC/FNIHB*** means the First Nations and Inuit Health Branch of Health Canada.

(20) ***Health Canada*** or ***HC*** means the federal Department of Health.

(21) ***Health Governance Structure*** means the structure described in section 4.

(22) ***Health Partnership Accord*** means the accord referenced in recital "C".

(23) ***Implementation Committee*** means the interim body referred to in section 7.1(1).

(24) ***Interim Health Plan*** means the plan or plans to be developed by the FNHA in accordance with the process set out in section 5.2.

(25) ***Interim Management Committee*** means the committee set out in section 7.3(1).

(26) ***Multi-Year Health Plan*** or ***MYHP*** means the plan to be developed by the FNHA in accordance with the process set out in section 5.3.

(27) ***NIHB Program*** means Canada's Non-Insured Health Benefits Program that funds a limited range of medically necessary health-related goods and services for eligible First Nations and Inuit persons which are not provided or insured through provincial or private health insurance programs.

(28) ***Parties*** mean Canada, British Columbia and the FNHS.

(29) ***Reciprocal Accountability*** has the meaning set out in section 2.2.

(30) ***Self-Governing First Nation*** means a First Nation in British Columbia that is recognized as self-governing by Canada as a result of a final self-government, treaty or land claims agreement.

(31) ***Sub-Agreements*** means the sub-agreements listed in Schedule 5.

(32) ***TCA:FNHP*** means the *Transformative Change Accord: First Nations Health Plan* (2006).

(33) ***TFNHP*** means the *Tripartite First Nations Health Plan* (2007).

(34) ***Transfer of Federal Health Programs*** has the meaning set out in section 6.3(1).

(35) ***Transition Team*** has the meaning set out in section 7.2(1).

(36) ***Tripartite Committee*** means the committee described in section 4.3.

SECTION 2 – PURPOSE AND NATURE OF THIS AGREEMENT

2.1 Purpose

(1) The purpose of this Agreement is to give legal expression to the Parties' commitment, under the *British Columbia Tripartite First Nations Health – Basis for a Framework Agreement on Health Governance (2010)* to conclude a Framework Agreement, and to their shared goal of improving the health and well-being of First Nations individuals and communities in British Columbia as envisioned in the *Tripartite First Nations Health Plan* (2007) by ensuring that BC First Nations are fully involved in health program and service delivery and decision-making regarding the health of their people in British Columbia. This Agreement sets out the Parties' specific commitments relating to the implementation of that vision, including:

(a) the Transfer of Federal Health Programs to the FNHA;

(b) the planning, design, management and delivery of FN Health Programs by the FNHA;

(c) the building of a more integrated health system for First Nations under the new Health Governance Structure;

(d) the active participation of Canada and British Columbia in the new Health Governance Structure, as part of the wider health partnership with BC First Nations; and

(e) the performance and accountability requirements of the Parties.

(2) The Parties acknowledge that Federal Health Programs, other than the NIHB Program, are aimed primarily at Status Indians resident on reserve in BC, with the NIHB Program being aimed at all Status Indians resident in BC. The Parties anticipate that as the FNHA enters into relationships with the BC Ministry of Health and BC Health Authorities, including the provision of funding, such relationships may also benefit other First Nations persons in BC, the wider aboriginal population in BC and potentially the non-aboriginal population.

2.2 Reciprocal Accountability

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

2.3 General Nature of the Framework Agreement

(1) The Parties recognize and agree that this Agreement reflects the state of their knowledge and understandings at the time of its drafting. With this Agreement, the Parties intend to enter into a long-term arrangement that will evolve over time. The Parties therefore agree to work together cooperatively in order to address the need, should it arise, for variations or additions to the terms of this Agreement.

2.4 First Nations Health Council Endorsement

(1) The FNHC is an unincorporated political organization, certain of whose members are signing this Agreement to express their support and endorsement of its contents in view of the FNHC mandate to oversee negotiations for this Agreement on behalf of BC First Nations. For greater certainty, the FNHC members shall not, by reason of any of them signing this Agreement:

a. be personally responsible or liable for any operational matters under this Agreement, including the planning, design, management or delivery of any health programs or services or for the actions or inactions of the FNHS or the FNHA or any person or Party under this Agreement;

b. admit any responsibility for any actions or inactions of the FNHC under this Agreement; or

c. have any rights or obligations of a "Party" or "Parties" under this Agreement.

(2) This provision shall not modify or limit any rights, obligations, responsibilities or liabilities of the FNHC members which may exist or arise at law independent of their signing this Agreement.

SECTION 3 - NO PREJUDICE

3.1 No Prejudice

(1) This Agreement shall not have the effect of, or be interpreted as:

(a) recognizing, affirming or denying, any aboriginal or treaty rights of First Nations;

(b) abrogating or derogating from (i) any existing aboriginal and treaty rights of First Nations; or (ii) the application and operation of section 35 of the *Constitution Act, 1982* to such rights;

(c) ending or altering the evolving fiduciary relationship between the Crown and BC First Nations;

(d) altering any responsibilities of Canada and British Columbia for First Nations health, except to the extent that the means of discharge of any such responsibility may change, in accordance with the law, in respect of the planning, design, management and delivery of health care programs and services on behalf of BC First Nations people under or as a result of this Agreement;

(e) modifying any treaty or creating a new treaty within the meaning of the *Constitution Act, 1982*;

(f) being prejudicial to any applications, court actions, negotiations or settlements with respect to land claims or land entitlements involving any of the BC First Nations; or

(g) being prejudicial to the implementation of any inherent right of self-government or any agreements that may be negotiated with respect to self-government with and of BC First Nations.

(2) The Parties acknowledge that the arrangements entered into under this Agreement are not intended to determine, delineate, or define:

(a) the distribution of powers between Canada and British Columbia in relation to health; or

(b) the scope of federal jurisdiction under section 91(24) of the *Constitution Act, 1867*.

SECTION 4 – NEW HEALTH GOVERNANCE STRUCTURE

4.1 General

(1) The new Health Governance Structure shall be composed of the following elements:

(a) a First Nations Health Authority (FNHA);

(b) a Tripartite Committee on First Nations Health (Tripartite Committee);

(c) a First Nations Health Council (FNHC);

(d) a First Nations Health Directors Association (FNHDA).

4.2 First Nations Health Authority (FNHA)

(1) The FNHS shall, as soon as possible after execution of this Agreement, take the necessary steps to establish the FNHA, a non-profit legal entity, representative of and accountable to BC First Nations that will reflect a structure to be developed by BC First Nations through a community engagement exercise. It shall be constituted with the good governance, accountability, transparency and openness standards which are set out in Schedule 4 or such other standards as are consistent with or exceed those standards.

(2) The FNHA shall, among other things:

(a) plan, design, manage, deliver and fund the delivery of FN Health Programs;

(b) receive federal, provincial and other health funding for or to support the planning, design, management and delivery of FN Health Programs and to carry out other health and wellness related functions;

(c) collaborate with the BC Ministry of Health and BC Health Authorities to coordinate and integrate their respective health programs and services to achieve better health outcomes for First Nations in British Columbia;

(d) incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into the FN Health Programs, recognizing that these may be reflected differently in different regions of BC;

(e) establish standards for the FN Health Programs that meet or exceed generally accepted standards;

(f) collect and maintain clinical information and patient records and develop protocols with the BC Ministry of Health and the BC Health Authorities for sharing of patient records and patient information, consistent with law;

(g) over time, modify and redesign health programs and services that replace Federal Health Programs through a collaborative and transparent process with BC First Nations to better meet health and wellness needs;

(h) design and implement mechanisms to engage BC First Nations with regard to community interests and health care needs;

(i) enhance collaboration among First Nations Health Providers and other health providers to address economies of scale service delivery issues to improve efficiencies and access to health care;

(j) carry out research and policy development in the area of First Nations health and wellness;

(k) maintain financial records and prepare financial statements in accordance with generally accepted accounting standards in the province of BC;

(l) be audited on an annual basis by an independent auditor recognized in the province of BC; and

(m) make its accounting records and audit reports available to its members, Canada and British Columbia and the Auditor General of Canada and the Auditor General of British Columbia upon request to conduct or cause to be conducted a financial or performance audit.

(3) The FNHA may undertake other functions, roles and responsibilities connected to health and wellness of First Nations and other aboriginal people in BC.

(4) The FNHS shall act as the interim FNHA provided that the FNHS meets the minimum criteria set out in subsections 4.2(1) and (2) prior to undertaking that role.

(5) Following community consultation the FNHC may conclude that the FNHS shall act as the FNHA on a permanent basis or that for operational reasons a different legal entity should be constituted as the FNHA. In this latter case, the Parties undertake to take all steps necessary to ensure a seamless successorship from the FNHS to the new entity. These steps shall include such new entity becoming a Party to this Agreement or otherwise taking legally binding steps to adopt the obligations that are set out for the FNHA in this Agreement and the consequent release of the FNHS from such obligations.

(6) Successorship under subsection 4.2(5) is restricted to a successor legal entity that itself meets the minimum criteria established under subsections 4.2(1) and (2) and may include a statutory body.

4.3 Tripartite Committee on First Nations Health

(1) A Tripartite Committee shall be established which will be co-chaired by the following: Deputy Minister of the BC Ministry of Health, the Assistant Deputy Minister of HC/FNIHB and the Chairperson of the board of the FNHA. The membership of the Tripartite Committee will also include the following persons or their delegates:

(a) the President/ Chief Executive Officers of each of the BC Health Authorities;

(b) the Provincial Health Officer under the BC *Public Health Act* and the Aboriginal Health Physician Advisor;

(c) the Chairperson and Deputy Chairperson of the FNHC;

(d) one representative from each of the 5 First Nations regional tables;

(e) the Chief Executive Officer of the FNHA;

(f) the President of the FNHDA;

(g) the appropriate Associate Deputy Minister and Assistant Deputy Minister of the BC Ministry of Health; and,

(h) any other non-voting, observer or full members as agreed to by the Tripartite Committee.

(2) The Parties shall ensure that the Tripartite Committee performs the following functions:

(a) meets at least twice per year;

(b) coordinates and aligns planning, programming, and service delivery between the FNHA, BC Health Authorities and the BC Ministry of Health, including the review of their respective FNHA MYHP and BC Regional Health Authorities' Aboriginal Health Plans consistent with the purposes of this Agreement;

(c) facilitates discussions and coordinates planning and programming among BC First Nations, British Columbia and Canada on all matters relating to First Nations health and wellness;

(d) provides a forum for discussion on the progress and implementation of this Agreement and other health arrangements including the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006), the *Tripartite First Nations Health Plan* (2007) and the Health Partnership Accord;

(e) prepares and makes public an annual progress report for the Minister of Health (BC), the Minister of Health (Canada) and the FNHC on the progress of the integration and the improvement of health services for First Nations in British Columbia; and

(f) undertakes such other functions as the Tripartite Committee members may from time to time agree, and which are consistent with the purposes and intent of this Agreement and its terms of reference.

4.4 First Nations Health Council (FNHC)

(1) The FNHC is an unincorporated association composed of fifteen (15) members. It is a political and advocacy organization, representative of and accountable to BC First Nations, with a mandate to serve as the advocacy voice of BC First Nations in achieving their health priorities and objectives.

(2) The FNHC undertakes the following support and advocacy functions for and on behalf of BC First Nations consistent with its mandate, including:

(a) supporting and assisting BC First Nations in achieving their health priorities and objectives;

(b) advocacy on health issues and health services for First Nations people in BC;

(c) providing a BC First Nations leadership perspective to research, policy and program planning processes related to First Nations health in BC; and

(d) providing continued leadership for the implementation of the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) and the *Tripartite First Nations Health Plan* (2007).

(3) The FNHC may, with the approval of BC First Nations, alter its structure and mandate without the consent of the Parties, provided that it continues to fulfill the roles and functions set out in subsections 4.4 (1) and (2).

4.5 First Nations Health Directors Association (FNHDA)

(1) The FNHDA is a society under the BC *Society Act* with members representing the Vancouver Coastal, Vancouver Island, Fraser, Interior and North regions of British Columbia.

(2) The FNHDA has a mandate, *inter alia*, to:

(a) represent health directors and managers working in First Nation communities;

(b) support education, knowledge transfer, professional development and best practices for health directors and managers of First Nation Health Providers; and

(c) act as an advisory body to the FNHC and FNHA on research, policy, program planning and design related to administration and operation of health services in First Nation communities.

4.6 Operation of the Health Governance Structure

(1) The FNHC may advise the FNHA in a manner consistent with the FNHC's mandate but shall not direct or purport to direct the FNHA.

(2) Members of the FNHA shall act in accordance with the FNHA constitution and by-laws of the FNHA and shall not participate in the day-to-day decision-making and operations of the FNHA.

(3) The FNHDA may advise the FNHA in regard to matters which are consistent with its mandate but it shall not direct or purport to direct the FNHA.

(4) The Tripartite Committee may advise each of the Parties and the FNHA in regard to matters which are consistent with its mandate, but it shall not direct or purport to direct the Parties or the FNHA.

SECTION 5 - FNHA – OPERATION AND PROVISION OF FN HEALTH PROGRAMS

5.1 Operations

The FNHA shall:

(1) commence negotiations with Canada immediately following the signing of this Agreement, and make best efforts to conclude within two (2) years of the signing of this Agreement or such later time as the FNHA and Canada agree, the Sub-Agreements and the Canada Funding Agreement in order to effect, facilitate and support the Transfer of Federal Health Programs; and

(2) negotiate any funding agreements that may be offered by British Columbia.

5.2 Interim Health Plan

(1) The FNHA shall prepare an annual Interim Health Plan that sets out its start-up plans, goals, priorities, program plans and services, health performance standards, anticipated allocation of resources and the use of funding to be provided by Canada and British Columbia. This Plan shall be provided by the FNHA to its members, Canada and British Columbia.

(2) The Interim Health Plan shall be prepared taking into account such advice and inputs set out in section 5.3(4) as are available at the time of drafting and shall reflect that the Transfer of Federal Health Programs may occur in stages.

(3) The Interim Health Plan shall be prepared on an annual basis until such time as the Transfer of Federal Health Programs is substantially complete.

5.3 Multi-Year Health Plan

(1) Upon expiry of the final Interim Health Plan, the FNHA shall present a five (5) year MYHP that sets out its goals, priorities, program plans and services, health performance standards, anticipated allocation of resources and use of funding to be provided by Canada and British Columbia.

(2) The MYHP shall be updated yearly and may be amended from time to time. A copy of the update and any amendments shall be provided by the FNHA to its members, Canada, and

British Columbia. Canada or British Columbia may disclose the MYHP in accordance with applicable freedom of information or access to information legislation and will inform the FNHA of any request for access to the MYHP and give the FNHA the opportunity to propose limits to the disclosure in accordance with the relevant legislation.

(3) The MYHP shall:

(a) include planning for the design, management and delivery of FN Health Programs, services and operations in order to best serve the health and wellness needs of First Nations in British Columbia;

(b) separately identify and budget for funding to be provided by Canada under the Canada Funding Agreement and by British Columbia under Schedule 2 of this Agreement;

(c) describe the FNHA's capital planning process for the construction, renovation and operation and maintenance of community-based health facilities in the province of BC and describe its systems for managing funding arrangements with First Nation Health Providers;

(d) address any requirements of the Sub-Agreements or funding arrangements entered into with Canada and British Columbia; and

(e) contain sufficient information and planning to assist the fulfillment of sections 4.3, 6.1 and 6.2.

(4) The MYHP shall take into account:

(a) the health needs of the First Nation population in BC, and input and feedback from BC First Nations and the five (5) First Nation regional tables;

(b) the advice from the governance structure members (the Tripartite Committee, the FNHC and the FNHDA);

(c) the results of the discussions between the FNHA and BC Health Authorities in section 6.2(2)(a); and

(d) the available resources of the FNHA.

5.4 Annual Reports

The FNHA shall prepare a summary service plan that will reflect the current health plan as outlined in section 5.2 or 5.3 and an Annual Report for its members on all of its activities, revenues, expenditures, achievements, and challenges for each fiscal year and its planning for the same matters for the following fiscal year. The summary service plan and Annual Report shall be provided to Canada and British Columbia and made available to the public.

5.5 Changes

The requirements for Interim Health Plans, the MYHP, summary service plan and the Annual Report may be further specified or varied on the consent of all Parties by way of terms to be contained in funding agreements entered into between the FNHA and Canada or the FNHA and British Columbia, and shall not require an amendment to this Agreement.

SECTION 6 - NEW ROLES AND RELATIONSHIPS

The Parties are committed to establishing a new and enduring relationship, based on respect, Reciprocal Accountability, collaboration, and innovation, that is conducive to the pursuit of improved health and wellness for First Nations in BC. Within this new relationship, the Parties have distinct but interrelated roles as described below.

6.1 FNHA – Collaboration and Integration

(1) The FNHA shall:

(a) establish working relationships with Health Canada, the BC Ministry of Health, BC Health Authorities and other health and health-related organizations as necessary;

(b) support a regional structure which allows First Nations to collaborate amongst themselves, with BC Health Authorities and with the FNHA;

(c) work collaboratively with the BC Ministry of Health and BC Health Authorities on the design and delivery of provincial health services available to First Nations in BC, to address gaps in health services and to better coordinate such services with FN Health Programs so as to improve efficiency and effectiveness of health care for First Nations in BC;

(d) work with the BC Health Authorities to examine and supplement health data collection, health status monitoring, and reporting systems used by the BC Health Authorities which include First Nations-determined indicators of health and wellness;

(e) work with the BC Ministry of Health and BC Health Authorities to integrate First Nation models of wellness into the health care system, to improve health outcomes and wellness for First Nations in BC;

(f) develop clinical information and patient record systems and protocols with the BC Ministry of Health and BC Health Authorities for the sharing of patient records, consistent with the law, to better serve First Nations patients and to enable greater First Nations control over the use, collection and access to health data relevant for the improvement of health services and to better monitor and report on First Nations health in BC;

(g) provide First Nations health program and policy advice to Canada, the BC Ministry of Health, BC Health Authorities, service providers, and agencies and seek to enhance the BC First Nations' opportunities to work with relevant government departments and agencies to improve the health outcomes of First Nations in BC; and

(h) enhance its ability to build multi-sectoral partnerships to better address the social determinants affecting the health status of First Nations.

6.2 British Columbia Ministry of Health and BC Health Authorities

(1) British Columbia shall create and support the operations of the Tripartite Committee forthwith after execution of this Agreement in accordance with section 4.3 and will direct all BC Health Authorities to participate on this Committee.

(2) British Columbia shall, as soon as practicable following creation of the FNHA:

(a) consistent with the BC *Health Authorities Act*, direct BC Health Authorities to work collaboratively with BC First Nations in their respective regions to:

(i) develop and review their respective Aboriginal Health Plans and First Nations Community Health and Wellness Plans with the goal of achieving better coordination in health planning. Such plans should identify needs that are unique or specific to each region;

(ii) collaborate regarding the delivery of health care services for aboriginal people; and

(iii) discuss innovative arrangements for service delivery where appropriate, and, where appropriate, establish funding arrangements at a time mutually agreed upon. These arrangements shall be planned and determined at a local and regional level between the FNHA, regional tables, and BC Health Authorities;

(b) direct BC Health Authorities to work with the BC Ministry of Health and the FNHA to explore options for entering into agreements with the FNHA on record and patient information sharing, in keeping with applicable privacy legislation;

(c) work with the Provincial Health Officer to change the role of the Provincial Aboriginal Health Physician Advisor to that of a Deputy Provincial Health Officer so as to work with the FNHA to improve, among other things, the quality of data being collected and the health indicators available for First Nations health and wellness; and

(d) enter into a funding agreement with the FNHA for the funding agreed to, on terms and conditions as outlined in Schedule 2.

6.3 Canada and the FNHA - the Transfer of Federal Health Programs

(1) Canada shall, under the Canada Funding Agreement, provide funding to the FNHA to support the Transfer of Federal Health Programs. The Transfer of Federal Health Programs shall occur in phases or blocks as the FNHA and Canada agree and shall be completed within two (2) years of the signing of this Agreement, or such later time as both Canada and the FNHA agree. In this Agreement, a "Transfer of Federal Health Programs" means:

(a) with respect to the FNHA, the assumption of responsibility for:

(i) the planning, design, management and delivery of one or more FN Health Programs to replace Federal Health Programs, subject to and in accordance with the terms of this Agreement, and the Canada Funding Agreement; and

(ii) all administrative, policy and other support functions required to plan, design, manage and deliver or fund the delivery of FN Health Programs;

(b) with reference to Canada, the cessation of:

(i) the planning, design, management and delivery, or the funding of the delivery of Federal Health Programs replaced under paragraph (a); and

(ii) all administrative, policy and other support functions required to plan, design, manage and deliver or fund the delivery of such Federal Health Programs; and

(c) the provision of funding by Canada under the Canada Funding Agreement in order to fund or assist in funding the FN Health Programs and related administrative, policy and other support functions.

(2) Canada shall negotiate and make best efforts to conclude the Canada Funding Agreement for any Transfer of Federal Health Programs, and to amend the Canada Funding Agreement as necessary for any subsequent Transfer or Transfers of Federal Health Programs, provided that:

(a) the FNHA has been established and is operating in accordance with section 4.2 of this Agreement;

(b) the FNHA has developed a satisfactory Interim Health Plan or Multi-Year Health Plan, as the case may be, for its operations in accordance with sections 5.2 and 5.3;

(c) the implementation and transition steps in section 7 relevant to any Transfer of Federal Health Programs have been completed; and

(d) the Sub-Agreements required for any Transfer of Federal Health Programs have been completed, Canada agreeing that it will use best efforts to conclude such Sub-Agreements.

(3) Canada shall, during the period of time from the signing of this Agreement until the date or dates for the Transfer of Federal Health Programs to the FNHA, maintain the budget allocation to the HC/FNIH Regional Office for the First Nations and Inuit Health program at a level no less than that of the allocation in the fiscal year of the signing of this Agreement.

(4) Canada shall establish the Interim Management Committee and undertake the functions set out for the HC/FNIH Regional Office as part of that committee in section 7.3.

(5) Canada shall provide funding to the FNHA subject to and in accordance with sections CF 10, CF 11 and CF 12 of Schedule 1.

SECTION 7 - IMPLEMENTATION

7.1 Implementation Committee and Plan

(1) As soon as practicable after the signing of this Agreement, the Parties shall establish an Implementation Committee with the mandate to provide general planning and coordination, as directed by the Parties, for the implementation of this Agreement over a five (5) year period. Canada, British Columbia, the FNHC and the FNHS shall each appoint a representative to the Committee. This Committee shall act on consensus and may establish sub-committees and add members as it deems necessary.

(2) The Parties intend that the Implementation Committee will take all steps reasonably necessary to advance the planned transfer and integration process set out in this Agreement based on the consensus of the committee members, including but not limited to:

(a) development of an implementation plan and monitoring the implementation of this Agreement;

(b) identifying timelines for the Transfer of Federal Health Programs from Canada and the assumption of all operational functions and responsibilities by the FNHA for that purpose;

(c) identifying timelines and implementation plans for the transfer of any agreed upon provincial programs, services and functions to the FNHA;

(d) establishment of Transition Team referred to in section 7.2; and

(e) engaging and communicating with First Nations and other stakeholders on implementation.

7.2 Transition Team and Plan

(1) The Implementation Committee shall establish a Transition Team to develop a transition plan for the Transfer of Federal Health Programs. The Transition Team will include a senior officer of the FNHS or FNHA, and of the HC/FNIH Regional Office. The Transition Team shall coordinate activities associated with the Transfer of Federal Health Programs and may modify the transition plan as necessary.

(2) The Transition Team will dissolve on the date of the completion of the Transfer of Federal Health Programs.

7.3 Interim Management Committee

(1) Following the signing of this Agreement, an Interim Management Committee will be formed consisting of the Regional Director of the HC/FNIH Regional Office and an individual designated by the FNHS. This Committee will review and discuss all significant and strategic level management, program or policy issues that would be decided on by the Regional Director of the HC/FNIH Regional Office and attempt to reach agreement thereon. These discussions will happen, where possible, prior to the Regional Director making a decision. The Interim Management Committee will meet as frequently as required but no less than two times per month.

(2) The Interim Management Committee will also establish a senior management team made up of the senior managers of the HC/FNIH Regional Office and the new senior managers of the FNHA. This senior management team will facilitate transition and learning by FNHA managers of the functions, operations and procedures of the HC/FNIH Regional Office to be assumed by the FNHA. Such transition and learning shall include opportunities to meet with representatives of HC/FNIHB in Ottawa. The senior management team will also work closely with the Transition Team and support the implementation of the transition plan.

(3) The Interim Management Committee will dissolve on the date of the completion of the Transfer of Federal Health Programs.

7.4 Confidentiality

(1) Members of the Implementation Committee, Transition Team, the Interim Management Committee and the senior management team who are not officers of Canada shall be required to sign any confidentiality and non-disclosure agreements reasonably required by Canada.

7.5 Implementation Funding

(1) Canada will contribute funding support for the implementation and transition costs of the FNHS required to establish the FNHA and its operations and to transition programs, services, and functions to its management. Canada will provide a one-time payment or payments of up to $17 million to the FNHS to contribute to such costs upon the signing of this Agreement and pursuant to a funding agreement or agreements to be negotiated by Canada and the FNHS in accordance with section CF 13 of Schedule 1.

7.6 Capacity Support

(1) Canada agrees that the FNHA may have access to administrative, program and professional officers and specialists of Health Canada for the purposes of their providing advice or other support to the FNHA in a manner to be agreed between the FNHA and Canada.

SECTION 8 - ONGOING COMMITMENTS OF THE PARTIES

8.1 Meetings

(1) In order to support the functioning and implementation of this Agreement, the Parties agree to convene the following meetings:

(a) A biennial meeting of the political representatives of the Parties as represented by the Chair of the First Nations Health Council, the Minister of Health (Canada), and the Minister of Health (British Columbia), or their designates.

(b) A governance partnership meeting to be held at least every eighteen (18) months, with senior representatives of the Parties to discuss the implementation of this Agreement and the overall functioning of the new relationship. This could include the formation of multi-party working groups to study and address any issues related to the implementation of this Agreement or any Sub-Agreements.

(c) Meetings at least once every eighteen (18) months between the FNHC and representatives of BC First Nations and First Nation Health Providers to discuss the implementation of this Agreement and the operation of the new Health Governance Structure.

(d) An annual meeting of the ADM HC/FNIHB and the CEO of the FNHA to discuss their respective policies, priorities and planning.

(e) Twice annual meetings of the HC/FNIHB Branch Director Generals with responsibility for community programs, primary care, public health and NIHB with senior officials of the FNHA to share information and experiences.

(f) Annual meetings between Canada (Aboriginal Affairs and Northern Development Canada) and the FNHC at the AANDC quality of life table and at the federal interdepartmental committee on aboriginal issues to discuss health and issues related to the social determinants of health.

(g) Annual meetings between the Deputy Minister of Health of British Columbia and the FNHA and mutually agreed-upon fellow Deputy Ministers will be scheduled to discuss policies and activities which may impact on the health of First Nations persons.

(2) The commitments made in this section may be amended and varied from time to time with the consent of the affected Parties.

8.2 Unforeseen Circumstances

(1) In the event of an unforeseen circumstance of a health emergency or natural disaster which would have a significant capacity or financial impact on the FNHA, Canada and British Columbia shall, with the FNHA, jointly assess the impact and required measures to address the situation. Any agreement to provide new funding or other assistance to the FNHA will be made by the Parties in writing.

SECTION 9 – OTHER

9.1 Legislation

(1) British Columbia commits to engage in a tripartite collaborative process to assess whether there is a need to enshrine any authorities and powers for the FNHA in provincial legislation or regulation. If all of the Parties agree that such a need exists, the BC Ministry of Health will seek to obtain the necessary legislative or regulatory changes.

(2) Canada commits to explore ways to acknowledge and express support for implementation of this Agreement through federal legislation.

9.2 Population and Public Health

(1) The BC Ministry of Health and the FNHA shall explore and identify measures, including possible legislative and regulatory mechanisms that might be of assistance to address matters of population and public health for the purposes of this Agreement consistent with the goal of this Agreement to build a more integrated health system that serves to help improve the health and well-being of First Nations and their communities in British Columbia.

9.3 Medical Service Plan (MSP) Premiums

(1) The Parties have agreed, pursuant to a separate letter of understanding to be reached by December 30, 2011, to enter into a discussion process regarding MSP premiums established under the *Medicare Protection Act* paid on behalf of Status Indian people in British Columbia.

SECTION 10 – TRIPARTITE EVALUATION

(1) The Parties shall jointly evaluate the implementation of this Agreement every five (5) years. This evaluation shall consider the purpose and intent of this Agreement as set out in the Recitals and section 2 and be carried out within the wider context of the health partnership with BC First Nations.

(2) The Parties shall, within eighteen (18) months of the signing of this Agreement, prepare an evaluation plan and begin collecting data and reports to track at least the following:

(a) Health indicators:

(i) life expectancy at birth;

(ii) mortality rates (deaths due to all causes);

(iii) Status Indian youth suicide rates;

(iv) infant mortality rates;

(v) diabetes rates;

(vi) childhood obesity rates;

(vii) the number of practicing First Nations health care professionals who are registered or otherwise accepted members of recognized health professions under the BC *Health Professions Act*; and

(viii) any other additional indicators, including wellness indicators supported by the governance stakeholders; namely the Tripartite Committee, the FNHC and the FNHDA.

(b) Governance, tripartite relationships and integration:

(i) the effectiveness of the new Health Governance Structure described in section 4; and

(ii) the effectiveness of the new federal, provincial and First Nation relationships set out in section 6.

(3) A tripartite evaluation report will be finalized within one year following the first five year period of the Transfer of Federal Health Programs. The report shall be made public.

SECTION 11 – DISPUTES

11.1 Informal Resolution

(1) The Parties are committed to working collaboratively to develop harmonious working relationships and to prevent, or alternatively, to minimize disputes about their respective rights or obligations under this Agreement. To that end, the Parties will:

(a) establish clear lines of communication and articulate their expectations about the interpretation of this Agreement, and

(b) seek to address anticipated disputes in the most expeditious and cost-effective manner possible.

(2) The Parties nevertheless acknowledge that disputes may arise about their respective rights or obligations under this Agreement and agree that they will strive to resolve any such disputes in a non-adversarial, collaborative and informal atmosphere.

(3) If a dispute arises in relation to the respective rights and obligations of any Party under this Agreement, the Parties to that dispute shall each nominate a representative who shall promptly and diligently make all reasonable, good faith efforts to resolve the dispute.

(4) Where a dispute is between fewer than all of the Parties, those Parties involved in the dispute will inform the other Party and may ask the other Party to assist them in attempting to resolve the dispute. Any Party asked to assist may accept or decline such a role in its sole discretion.

(5) Nothing prevents the Parties, at any stage of a dispute, from agreeing to refer the dispute to mediation on such terms as they may agree. In the event that a dispute is referred to mediation, the Parties will share equally in the fees and expenses of the mediator and will otherwise bear their own costs of participation in the mediation.

(6) All information exchanged during this dispute resolution process shall be regarded as "without prejudice" communications for the purpose of settlement negotiations and shall be treated as confidential by the Parties and their representatives, unless otherwise required by law. However, evidence that is independently admissible or discoverable shall not be rendered inadmissible or non-discoverable by virtue of its use during the dispute resolution process.

(7) Before a dispute is submitted to a court of competent jurisdiction, the principals of the Parties shall be notified of the dispute and given a final opportunity to consider a resolution thereof.

11.2 Formal Resolution

(1) Subject to subsection 11.1(7), if any Party to the dispute determines that the dispute cannot be resolved under section 11.1, the dispute may be submitted by that Party to a court of competent jurisdiction.

SECTION 12 - TERMINATION

12.1 Termination Notice

(1) The Parties intend this Agreement to be a long term arrangement which may be updated and amended from time to time. However, any Party may terminate this Agreement by providing at least eighteen (18) months written notice to the other Parties.

(2) Upon delivery of a termination notice by any Party under section 12.1(1), the Party providing notice shall offer to host a meeting with the other Parties within one month, at which time all Parties shall attend with an appropriate official to consider whether there is any basis to continue with this Agreement in whole or in part, and with what changes or amendments as may be necessary for that purpose.

(3) The Parties, or any two of them, together with such other persons or parties as may be deemed appropriate by the participating Parties, may also meet as necessary to consider whether any parts of the arrangements put in place under or as a result of this Agreement may be

continued under new or alternative arrangements between all or some of the Parties and with any new parties, as the case may be, and on what terms.

(4) At any time following the delivery of a termination notice, the Party serving it may, with the consent of all of the other Parties:

(a) extend or reduce the eighteen (18) month notice period for the termination;

(b) enter into a dispute resolution process with the other Parties or any one of them on terms to be agreed between the participating Parties, and the Party providing the termination notice may agree to suspend that notice during such process; or

(c) withdraw the termination notice.

12.2 Termination Process

(1) In the event that there is no agreement within six (6) months or such further time as all Parties agree following the delivery of a termination notice under s. 12.1(1):

(a) between all Parties to continue with this Agreement on the same or amended terms under s. 12.1(2); or

(b) between all or any two of the Parties and any new parties to new or alternative arrangements under s. 12.1(3),

the Parties shall notify the principals of the Parties of the pending termination so as to provide them with a final opportunity to consider whether there is any basis to continue with this Agreement or to develop alternative arrangements.

(2) In the absence of any agreement by the principals of the Parties to continue with this Agreement or to new or alternative arrangements under 12.2(1), the Minister of Health (Canada) shall, subject to obtaining appropriate authority and consistent with section 12.3, provide or fund the provision of such health programs and services for First Nations in British Columbia as are consistent with Canada's First Nations health programs and policies in existence at the time of termination of this Agreement and from time to time thereafter.

(3) For greater certainty, if this Agreement is terminated, British Columbia shall not therefore be responsible for programs and payments transferred by Canada to the FNHA.

12.3 Transition

Following the provision of a notice of termination under section 12.1(1) and up to the time that any new arrangements are put in place under sections 12.1 or 12.2, the Parties shall:

(1) abide by the terms of this Agreement;

(2) engage in a process with appropriate officials who shall meet as frequently as is reasonable and necessary to make plans for the smooth transitioning of health programs

and services that are the subject of this Agreement, with the intent of ensuring that there is no disruption to those programs and services; and

(3) take such steps as are reasonable, necessary and commensurate with their respective roles and responsibilities herein to ensure a smooth transition and minimal disruption to the delivery of the health programs and services that are the subject of this Agreement.

12.4 Effect of Termination on other Accords

For greater certainty, termination of this Agreement alone shall not cause or result in the termination of the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006) or the *Tripartite First Nations Health Plan* (2007).

SECTION 13 – GENERAL PROVISIONS

13.1 Interpretation – Nature of Agreement

(1) This Agreement is intended to provide BC First Nations, through the FNHA, with a framework for undertaking the planning, design, management and delivery, and funding the delivery, of FN Health Programs in accordance with its terms and subject to the laws of British Columbia and Canada.

(2) This Agreement is not a self-government agreement and does not transfer or confer any law-making powers from or to any Party or to the FNHA.

13.2 Entire Agreement

(1) This Agreement is legally binding in accordance with its terms and represents the entire legal agreement among the Parties in respect of its subject matter.

13.3 Amendment

(1) This Agreement may be amended in writing signed by duly authorized representatives of each of the Parties.

(2) An amendment to this Agreement takes effect on a date agreed to by the Parties to the amendment, but if no date is agreed to, on the date that the last Party required to consent to the amendment gives its consent.

13.4 Waiver

(1) No provision of this Agreement, and no performance obligations by a Party under this Agreement, may be waived unless the waiver is in writing and signed by the Party or Parties giving the waiver.

(2) No waiver referred to in subsection (1) shall be deemed to constitute a waiver of any other provision, obligation or default.

13.5 Governing Laws

(1) This Agreement shall be construed in accordance with the laws of the Province of British Columbia and all federal laws applicable therein. All actions or activities of the Parties undertaken pursuant to this Agreement shall be subject to the laws of the Province of British Columbia and all federal laws applicable therein.

(2) For greater certainty, the Parties recognize that neither Canada nor British Columbia has the authority, through this Agreement, to bind Parliament or the Legislature from amending federal or provincial legislation or regulations, respectively, with the possible effect of superseding this Agreement in part, or in its entirety.

13.6 Statutory References

Each reference to an enactment is deemed to be a reference to that enactment, and to the regulations made under that enactment, as amended or re-enacted from time to time.

13.7 Interpretation – references to certain organizations

It is understood that certain of the statutory, corporate, government or other bodies or organizations, including government branches, agencies or titled positions referred to in this Agreement may undergo changes to their names, functions or mandates from time to time or may cease to operate or exist. In these circumstances, the Parties agree to work cooperatively to amend this Agreement as necessary to keep this Agreement current and relevant in the face of such change, and otherwise agree that this Agreement should be given a contextual interpretation, so that such changes do not frustrate the purpose and intent of this Agreement if they are non-material or if the Parties can easily adapt their procedures to suit the new circumstances and without prejudice to any Party.

13.8 Other References

The insertion of headings and the division of this Agreement into sections are for convenience of reference only and shall not affect the interpretation thereof. In this Agreement, words importing the singular include the plural and vice versa and words importing gender include all genders. All references to the word "including" shall mean "including without limitation". All references in this Agreement to either "Canada" or "British Columbia" shall be interpreted so as to include, where appropriate, its duly authorized representative.

13.9 Further Assurances

Each of the Parties shall from time to time and within a reasonable time execute and deliver all such further documents and instruments and do all acts and things as the other Parties may reasonably require to effectively carry out or to better evidence or perfect the full intent and meaning of this Agreement.

13.10 Assignment

A Party may not assign this Agreement without the prior written consent of the other Parties. This Agreement shall enure to the benefit of and shall be binding upon the Parties and their respective successors and permitted assigns. This provision is without prejudice to the provisions of section 4.2(5).

13.11 Relationship of Parties

(1) Subject to subsection (3), nothing in this Agreement shall be deemed to constitute any Party, or the FNHA, a legal partner or agent of any other Party. Each Party will act on its own behalf and not on behalf of any other Party and at no time will any Party or the FNHA hold itself out to be the legal agent, employee or partner of any other Party. No Party hereto shall have the express or implied right or authority to assume or create any obligation on behalf of or in the name of any other Party, or to bind any other Party to any contract, agreement or undertaking with any other person.

(2) For greater certainty, none of the Parties to this Agreement shall be responsible or liable for:

(a) the actions or inactions of another Party, the FNHA or any First Nation Health Provider under or pursuant to this Agreement except to the extent they may have caused or contributed to such actions or inactions and are liable for the consequences according to applicable laws;

(b) any loss including economic loss or injury suffered by another Party, the FNHA or any First Nation Health Provider, or their respective employees, officers, agents, contractors or voluntary workers, resulting from or in any way related to carrying out activities under or pursuant to this Agreement, except to the extent that a Party may have caused or contributed to such actions or inactions and are liable for the consequences according to applicable laws; or,

(c) any loans, capital leases or other long term obligations of any Party or of the FNHA or any First Nation Health Provider resulting from or in any way related to carrying out activities under or pursuant to this Agreement.

(3) Nothing in this Agreement shall prevent any Party or the FNHA from acting as a legal partner or agent of another for any purpose connected to this Agreement where they expressly agree, or for any purposes unrelated to this Agreement.

13.12 Non Severability

If any provision of this Agreement is determined to be legally invalid or unenforceable by a court of competent jurisdiction, in whole or in part, that provision will be severed from this Agreement to the extent only of the invalidity or unenforceability and the Parties will negotiate in good faith to agree on a substitute provision that will remedy or replace the invalid or unenforceable provision and any related provisions that may be affected by the invalidity or unenforceability.

13.13 Notices

Any notice or other communication to be given to a Party under this Agreement shall be given in writing, and shall be sufficiently given if delivered personally or if sent by prepaid registered mail or fax to such Party as follows:

To Canada:

Name: Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada

Address: 200 Eglantine Driveway, Tunney's Pasture, Ottawa, Ontario K1A 0K9

Attention: Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada

Facsimile: 613-957-1118

To British Columbia:

Name: Assistant Deputy Minister, Population and Public Health, Ministry of Health

Address: 4-2, 1515 Blanshard St, Victoria BC, V8W 3C8

Attention: Assistant Deputy Minister, Population and Public Health, Ministry of Health

Facsimile: 250-952-1713

To the FNHS:

Name: Chief Executive Officer

Address: 1205-100 Park Royal South, West Vancouver BC V7T 1A2

Attention: Chief Executive Officer

Facsimile: 604-913-2081

or at such other address as the Party to whom such notice is to be given shall have last notified to the Party giving the same in the manner provided in this section. Any notice personally delivered to a Party shall be deemed to have been given and received on the day it is so delivered at such address. Any notice mailed to a Party shall be deemed to have been given and received on the fifth business day next following the date of its mailing provided no postal strike is then in effect or comes into effect within five business days after such mailing. Any notice transmitted by fax shall be deemed to be given and received on the day of its transmission.

13.14 Warranty of Authority

(1) Each Party represents and warrants that it has the necessary power, authority and capacity to enter into this Agreement and that its signatory has been duly authorized to sign this Agreement on its behalf.

(2) Following the initialling of this Agreement, BC First Nations will participate in a nation-based ratification process for the governance structure, functions, and relationships of a new First Nations health governance structure. This process will require a resolution of support ratifying this Agreement at a First Nations Health Council Assembly.

SECTION 14 - SCHEDULES

The Schedules to this Agreement consist of:

(1) Schedule 1 - Canada Funding

(2) Schedule 2 - British Columbia Funding

(3) Schedule 3 - List of Federal Health Programs

(4) Schedule 4 - FNHA Corporate Governance Requirements

(5) Schedule 5 – Operational Sub-Agreements to be negotiated

SECTION 15- EXECUTION

This Agreement may be executed and delivered by fax and in counterparts, and each counterpart when so executed and delivered shall be deemed original.

The Parties have executed this Agreement.

HER MAJESTY THE QUEEN IN RIGHT OF CANADA, as represented by the Minister of Health

Honourable Leona Aglukkaq
Minister of Health
Government of Canada

Ian Potter, Witness
Chief Federal Negotiator
Government of Canada

THE FIRST NATIONS HEALTH SOCIETY

Norman Joseph ("Joe") Gallagher
CEO, First Nations Health Society

Pierre Leduc, Witness
Chair, First Nations Health Society

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

Honourable Michael de Jong
Minister of Health
Province of British Columbia

Graham Whitmarsh, Witness
Deputy Minister of Health
Province of British Columbia

Endorsed by
THE FIRST NATIONS HEALTH COUNCIL

Grand Chief Douglas Colin ("Doug") Kelly
Chair, First Nations Health Council

Shawn A-in-chut Atleo, Witness
National Chief, Assembly of First Nations

SCHEDULE 1 – CANADA FUNDING

Part 1 - Ten (10) Year Canada Funding Agreement

CF 1. General: Canada will transfer an "Annual Federal Amount" to the FNHA under a Canada Funding Agreement to be negotiated in accordance with the terms of this Schedule. The Annual Federal Amount will be calculated in accordance with section CF 3 and be transferred for the purposes set out in the Interim Health Plan or Multi-Year Health Plan. The Annual Federal Amount will be paid toward all of the costs to be incurred by the FNHA for the delivery of its Interim Health Plan or Multi-Year Health Plan, inclusive of all related corporate and administrative expenses of any kind including employee pay and benefits, policy and program costs.

CF 2. Term: The Canada Funding Agreement will have a term of 10 (ten) years with funding amounts, program delivery and reporting functions organized on an April 1-March 31 "fiscal year" basis. The Canada Funding Agreement may be entered into at once or in stages for all or part of the Annual Federal Amount.

CF 3. The Annual Federal Amount: The Annual Federal Amount shall be calculated as follows:

(a) In the initial fiscal year of the Canada Funding Agreement, the Annual Federal Amount will be equal to the Base Year Amount set out in section CF 4 as adjusted under section CF 5 and as adjusted for those program components set out in tables 2 to 5 of Annex A to this Schedule which are transferred to the FNHA, from the date of transfer, bearing in mind that the Transfer of Federal Health Programs may occur in stages or blocks.

(b) In fiscal years two (2) three (3), four (4) and five (5) of the Canada Funding Agreement, the Annual Federal Amount will be the prior year's Annual Federal Amount (expressed on an annualized basis in the event of prior partial fiscal years) multiplied by the Annual Escalator set out in section CF 6 plus any additional program components set out in tables 2 to 5 of Annex A to this Schedule which are transferred to the FNHA during these fiscal years, bearing in mind that the Transfer of Federal Health Programs may occur in stages or blocks.

(c) In fiscal years six (6) through ten (10) of the Canada Funding Agreement, the Annual Federal Amount will be the prior year's Annual Federal Amount multiplied by a new Annual Escalator to be determined by Canada and the FNHA. If negotiations for a new Annual Escalator for fiscal years six (6) through ten (10) are not concluded before the fifth anniversary of that agreement, the FNHA will receive an Annual Federal Amount for the sixth fiscal year and subsequent fiscal years that it is equivalent to the fiscal year five (5) Annual Federal Amount. Canada and the FNHA may continue negotiations on the escalator until the expiry of the Canada Funding Agreement and if negotiations are concluded before then, a retroactive adjustment will be made for each of the fiscal years six (6) through ten (10) of the Canada Funding Agreement to pay the

FNHA any differences, without interest, resulting from application of the new Annual Escalator.

(d) If the Canada Funding Agreement takes effect on a date other than April 1, it will have partial initial and final fiscal years. The Annual Federal Amount for any partial fiscal years will be the amount that otherwise applies under this subsection and proportionally reduced by multiplying it by the number of days it will be paid in that fiscal year and dividing by 365.

CF 4. Base Year Amount: The "Base Year Amount", which has been calculated with reference to the total direct, indirect, support and administrative costs of Canada for funding, providing and administering all Federal Health Programs, is the "2008/9 amount" of $318,832,400 as set out in Annex A, Table 1, plus the Adjustment Factor set out in section CF 5.

CF 5. Adjustment Factor: The 2008-09 amount in section CF 4 will be adjusted to the effective date or dates of the transfer of funding for Federal Health Programs to the FNHA to become the Base Year Amount by way of the following adjustment factor ("Adjustment Factor"):

(a) the portion of the 2008/9 amount representing NIHB expenditures ($139,077,700) will be replaced by: (i) $163,455,600 if the transfer occurs in fiscal year 2011-12 or (ii) $172,511,700 if the transfer occurs in fiscal year 2012-13 or (iii) $182,079,200 if the transfer occurs in fiscal year 2013-14; plus

(b) the portion of the 2008/9 amount representing Regional Community Program Expenditures ($169,413,900) will be replaced by: (i) $178,234,900 if the transfer occurs in fiscal year 2011-12 or (ii) $181,378,300 if the transfer occurs in fiscal year 2012-13 or (iii) $184,596,800 if the transfer occurs in fiscal year 2013-14; plus

(c) the portion of the 2008/9 amount representing Capital expenditures ($10,340,800) will be replaced by: (i) $10,829,800 if the transfer occurs in fiscal year 2011-12 or (ii) $10,998,000 if the transfer occurs in fiscal year 2012-13 or (iii) $11,168,700 if the transfer occurs in fiscal year 2013-14.

If any of the programs referred to in (a) to (c) above are transferred in parts and in separate years, the funding for each part will be based on the funding level for the relevant year of transfer set out above.

CF 6. Annual Escalator: The Canada Funding Agreement will provide for fixed annual increases ("Annual Escalator") of 5.5% to the prior fiscal year's Annual Federal Amount (annualized) in fiscal years two (2), three (3), four (4) and five (5) of the Canada Funding Agreement provided that, and during the time that, the NIHB Program is included in the programs transferred to the FNHA pursuant to this Agreement. For any period of time during the above-noted fiscal years that the NIHB Program is not included in the programs transferred to the FNHA, the Canada Funding Agreement will provide for fixed annual increases of 4.5% to the prior year's Annual Federal Amount (annualized). Canada and the FNHA will commit to negotiate an Annual Escalator for the remaining fiscal years of the Canada Funding Agreement in accordance with subsections CF 3(c) and CF 9(a).

CF 7 Funding Flexibility: The Canada Funding Agreement will provide for flexibility in the allocation of resources and in the design and prioritization of programs. The Annual Federal Amount will not be reduced by any of the following:

(a) **Surplus funds / Carry-over:** The FNHA may retain and carry-over surpluses from any fiscal year for use in any subsequent fiscal year during the term of the Canada Funding Agreement for health programs and services in accordance with the FNHA's Interim Health Plan or Multi-Year Health Plan;

(b) **Block Funding / Sun-setting:** The Annual Federal Amount shall be provided as block funding. The FNHA may re-design, re-prioritize or cancel any programs within this block. In the event an ongoing program or service set out in Schedule 3 terminates or is cancelled by Canada nationally or regionally, there will be no deduction to the funding provided to the FNHA; and any related funds may be retained by the FNHA for investment in health programs and services in accordance with its Interim Health Plan or Multi-Year Health Plan (recognizing that the funding referred to in sections CF 11 and CF 12 are not part of the Annual Federal Amount and may sunset and will continue only to the end of the program or as set out herein); and

(c) **Funding from Other Sources:** The Annual Federal Amount will not be reduced if the FNHA obtains from other sources, including British Columbia or other federal government departments, additional funding for any of the FN Health Programs. The FNHA will in such cases use the related funding from the Annual Federal Amount as originally intended to enhance the programs or services in question or it may invest this amount in other FN Health Programs.

CF 8. Reporting: The FNHA will:

(a) Prepare an Annual Report in accordance with section 5.4 of this Agreement.

(b) Provide for the preparation of an independent evaluation every five (5) years that includes review of the FNHA's:

(i) plans and programs;

(ii) organizational structure and organizational effectiveness; and

(iii) management of First Nation Health Provider relationships and health benefit (former FNIHB) provider relationships.

This evaluation will be available to the FNHA members, Canada, British Columbia and the public.

CF 9. Renewal Procedures: Canada and the FNHA will review the funding and other provisions of the Canada Funding Agreement during its term as part of their regular review of that agreement and will plan for the update and renewal of that agreement as follows:

(a) Initial Five (5) Year Review: Canada and the FNHA will review the general and specific provisions of the Canada Funding Agreement and will hold discussions to negotiate the value of the Annual Escalator for the fiscal years six (6) through ten (10) of the Canada Funding Agreement during the fourth fiscal year of the initial Canada Funding Agreement.

(b) Ten (10) Year Reviews: For successor agreements to the initial Canada Funding Agreement, renewal negotiations will commence no later than one year prior to the expiry date of the initial or then current Canada Funding Agreement. If negotiations on the new agreement including its funding provisions are not concluded before the prior Canada Funding Agreement expires, Canada and the FNHA agree that for a period of two years they will enter into a new funding agreement, to be negotiated in accordance with section CF 13, with substantially the same terms and conditions as the prior agreement and at a funding level that matches the Annual Federal Amount for the last fiscal year of the prior agreement (expressed on an annualized basis in the event that the final fiscal year is partial).

Part 2 - Other Canada Funding Commitments

CF 10. New Programs and Services Funding

(1) The FNHA and Canada shall enter into discussions with respect to accessing any available federal funding for any new health or related programs, including any environmental remediation programs, and services which may be introduced by Canada from time to time on a national or regional basis.

(2) Additional funding will not be provided in respect of: (a) new federal health programs, services or operations which substantially replace any Federal Health Programs set out in Schedule 3 or for which funding has already been provided under an agreement between Canada and the FNHA; (b) national or regional funding changes for Federal Health Programs set out in Schedule 3 or substantially similar programs or their operations.

(3) Notwithstanding subsection CF.10(2), in the event that Canada introduces expanded beneficiary eligibility and associated funding for any federal health programs and services set out in Schedule 3 as a result of possible legislative amendments to the *Indian Act* (Canada) or decisions of the courts that result in an increased number of persons eligible to be registered as an Indian under that Act, Canada and the FNHA will work together to determine impacts and approaches to address such change. The FNHA and Canada shall enter into discussions with respect to accessing any federal funding that is made available nationally for any new or expanded programs or services to address such eligibility matters.

CF 11. Indian Residential Schools Program (IRS Program) Funding: Canada will provide funding to be paid on a time limited basis (not to exceed the duration of the IRS Program) pursuant to a funding agreement or agreements to be negotiated between Canada and the FNHA for the purpose of delivering the IRS Program. Such funding will be provided pursuant to a funding agreement or agreements to be negotiated by Canada and the FNHA in accordance with section CF.13.

CF 12. Top-Up Funding for the TFNHP: Canada will provide an additional annual contribution to the FNHA to be paid on a time limited basis, and if required, to ensure that the value of the federal contribution to the TFNHP in each full fiscal year of the Canada Funding Agreement is $10 million. The base amount for the TFNHP which is included in the Base Year Amount, is $6 million in 2008-9 fiscal year funds. When that amount, as adjusted by the applicable Adjustment Factor in section CF 5 and the Annual Escalator in section CF 6, reaches $10 million, the top-up will cease. Such top-up funding will be provided pursuant to a funding agreement or agreements to be negotiated by Canada and the FNHA in accordance with section CF 13.

Part 3 – Federal Funding Agreements

CF 13. General Terms and Conditions:

(1) Each funding agreement to be entered into by Canada and the FNHA or the FNHS pursuant to this Agreement shall contain such terms and conditions as the two Parties may negotiate provided that such terms and conditions, and the manner of payments to be made under the agreement, are consistent with federal Treasury Board policy and applicable laws, including the following:

(a) terms for the preparation by the FNHA or the FNHS of a health plan for the funding (including the Interim Health Plan or Multi-Year Health Plan for the Canada Funding Agreement);

(b) audit and financial reporting provisions specific to the funding provided by Canada;

(c) reporting provisions to members and Canada;

(d) if applicable, provisions for distributed payments to First Nation Health Providers in accordance with section CF 14;

(e) default and remedial powers for Canada up to and including the institution of third party management and suspension of funding in the event of a breach of the funding agreement by the FNHA or the FNHS; and

(f) provisions that the funding provided is subject to there being a sufficient unencumbered balance of an appropriation made by the Parliament of Canada, which appropriation must constitute a lawful authority for making the said payment during the fiscal year in which the payment becomes due.

CF 14. Funding Role of the FNHA – Funding First Nation Health Providers:

(1) The Canada Funding Agreement shall provide that where the FNHA acts as a funder of First Nation Health Providers in respect of FN Health Programs it shall:

(a) honour the terms of existing Canada CA's which may be assigned to the FNHA in accordance with the sub-agreement referred to in Schedule 5, section 7. Where a new funding agreement is required with a First Nation Health Provider, and for a period of two years following the implementation of this Agreement, the FNHA will enter into such new funding arrangements on terms which match the material terms of Canada CA's used with those Providers on the last day prior to implementation of this Agreement, and may thereafter revise its funding processes in a manner which best serves health needs and the requirements of this Agreement;

(b) use an open and transparent decision-making process, based on consultation with affected BC First Nations, regarding the selection of First Nation Health Providers and the programs and services they will be funded to receive;

(c) employ the use of written funding agreements with First Nation Health Providers which contain, at a minimum, program descriptions, flexibilities, performance standards, reporting, evaluation, audit, enforcement and recovery processes;

(d) support First Nation Health Providers to plan, manage, organize and otherwise carry out their responsibilities to deliver FN Health Programs to their communities, including the development of their Community Health and Wellness Plans; and

(e) have audit and enforcement policies and procedures sufficient to ensure full accountability of funding provided to First Nation Health Providers.

CF 15. Self-Governing First Nations:

(1) The FNHA may provide FN Health Programs to Self-Governing First Nations and may conclude arrangements including funding agreements to deliver such programs and services to any Self-Governing First Nation in whole or in part.

(2) Notwithstanding any other provision of this Schedule if:

(a) a Self-Governing First Nation that is receiving FN Health Programs from the FNHA for its members chooses to terminate such arrangements in whole or in part in order to provide any health programs or services for its members or others by itself or by means other than the FNHA; and

(b) Canada enters into funding arrangements with the Self-Governing First Nation for any health functions described in (a),

then the Annual Federal Amount shall be reduced by the value of the terminated FN Health Programs described in (a) as determined by Canada in consultation with the FNHA and the affected Self-Governing First Nation.

Annex A (Details of Canada Funding)

Annex A (Details of Canada Funding) contains certain 2008/9 budget information for Federal Health Programs. It is attached to this Schedule for use with reference to CF 3, CF 4 and CF 5

and for reference purposes only. In the event of a conflict or inconsistency between Annex A and this Agreement or Schedule, the terms of this Agreement and the Schedule, in that order, shall prevail.

Annex A

to Schedule 1 (Canada Funding) of the British Columbia Tripartite Framework Agreement on First Nation Health Governance

DETAILS OF CANADA FUNDING

Table 1: SUMMARY, BASE YEAR 2008-2009 AMOUNTS

PROGRAM/SERVICE	FUNDING
Regional Community Programs	$127,656,800
Tripartite First Nations Health Plan	$6,000,000
Regional Sun-setting Programs	$16,807,800
Non-Insured Health Benefits Program	$135,520,700
Capital	$10,340,800
Policy and Program Leadership (FNIHB HQ)	$7,819,300
Corporate and Management Services (includes EBP)	$12,839,900
Accommodations	$1,847,100
TOTAL BASE YEAR AMOUNT	**$318,832,400**

IMPLEMENTATION FUNDING (one-time funding)	**$17,000,000**
ANNUAL ESCALATOR	
All programs transferred	5.5%
NIHB not transferred	4.5%
Tripartite Health Plan Top Up (in 2008-09 value) * Payment starting in transfer year to top up amount to $10,000,000	$4,000,000 *

Table 2 – Details of Federal Funding for Program Transfer, Fiscal Year 2008-09 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2008-09 ($ 000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	133,656.8	0	0	133,656.8
Regional Sunsetters	16,807.8	0	0	16,807.8
Non-Insured Health Benefits (NIHB)	0	135,520.7	0	135,520.7
FNIHB HQ Policy and Programs	5,158.0	2,661.3	0	7,819.3
Corporate and Management	7,705.6	596.1	0	8,301.7
Employee Benefit Plan	4,238.6	299.6	0	4,538.2
Capital	0	0	10,340.8	10,340.8
Accommodations	1,847.1	0	0	1,847.1
TOTAL	169,413.9	139,077.7	10,340.8	318,832.4

Table 3 – Fiscal Year 2010-11 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2011/12 ($ 000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	139,061.3	0	0	139,061.3
Regional Sunsetters	16,838.6	0	0	16,838.6
Non-Insured Health Benefits (NIHB)	0	151,264.3	0	151,264.3
FNIHB HQ Policy and Programs	5,246.9	2,681.5	0	7,928.4
Corporate and Management	7,843.0	608.5	0	8,451.5
Employee Benefit Plan	4,375.9	326.9	0	4,702.8
Capital	0	0	10,662.0	10,662.0
Accommodations	1,847.1	0	0	1,847.1
TOTAL	175,212.8	154,881.2	10,662.0	340,756.0

Table 4 – Fiscal Year 2011-12 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2011-12 ($,000 (000's omitted))			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	141,881.8	0	0	141,881.8
Regional Sunsetters	16,854.4	0	0	16,854.4
Non-Insured Health Benefits (NIHB)	0	159,807.8	0	159,807.8
FNIHB HQ Policy and Programs	5,292.4	2,691.8	0	7,984.2
Corporate and Management	7,913.1	614.9	0	8,528.0
Employee Benefit Plan	4,446.1	341.1	0	4,787.2
Capital	0	0	10,829.8	10,829.8
Accommodations	1,847.1	0	0	1,847.1
TOTAL	178,234.9	163,455.6	10,829.8	352,520.3

Table 5 – Fiscal Year 2012-13 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2012-13 ($'000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	144,784.2	0	0	144,784.2
Regional Sunsetters	16,870.4	0	0	16,870.4
Non-Insured Health Benefits (NIHB)	0	168,832.5	0	168,832.5
FNIHB HQ Policy and Programs	5,338.5	2,702.3	0	8,040.8
Corporate and Management	8,020.8	621.4	0	8,642.2
Employee Benefit Plan	4,517.3	355.5	0	4,872.8
Capital	0	0	10,998.0	10,998.0
Accommodations	1,847.1	0	0	1,847.1
TOTAL	181,378.3	172,511.7	10,998.0	364,888.0

Table 6 – Fiscal Year 2013-14 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY OF ADJUSTMENTS FOR 2013-14 ($'000 Constants)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	147,770.9	0	0	147,770.9
Regional Sunsetters	16,886.6	0	0	16,886.6
Non-Insured Health Benefits (NIHB)	0	178,367.6	0	178,367.6
FNIHB HQ Policy and Programs	5,385.4	2,712.9	0	8,098.3
Corporate and Management	8,117.2	628.0	0	8,745.2
Employee Benefit Plan	4,589.6	370.6	0	4,960.2
Capital	0	0	11,168.7	11,168.7
Accommodations	1,847.1	0	0	1,847.1
TOTAL	184,596.8	182,079.2	11,168.7	377,844.7

SCHEDULE 2 – BRITISH COLUMBIA FUNDING

(1) British Columbia will provide funding to the First Nations Health Society (FNHS) to implement the commitments in the Transformative Change Accord: First Nations Health Plan (TCA:FNHP) and the Tripartite First Nations Health Plan (TFNHP), as described below:

Fiscal Year	Annual Funding Amount	
2011/12	$	4,000,000
2012/13		6,500,000
2013/14		8,000,000
2014/15		10,000,000
2015/16		11,000,000
2016/17		11,000,000
2017/18		11,000,000
2018/19		11,000,000
2019/20		11,000,000
	$	**83,500,000**

(2) British Columbia's obligation to provide funding under this Agreement is subject to the BC *Financial Administration Act*, which makes that obligation subject to an appropriation being available in the fiscal year of the Province of BC during which payment becomes due.

(3) This funding will be re-directed to the FNHA upon its creation and the same conditions will apply.

(4) In the event of termination of this Agreement, the BC Ministry of Health will pay the amounts described above to the FNHS or other agency. The conditions of payment shall be governed instead by the principles of the TCA:FNHP and the TFNHP. The FNHS and the BC Ministry of Health will enter into good faith negotiations during the eighteen (18) month notice period to enter interim and final agreements in respect of the deliverables, funding and other matters respecting the goals of the funding as described in the above documents and this schedule. There will be no payments until an agreement is reached.

Reporting

(5) The FNHS will provide to British Columbia the following reports, in the form and manner proscribed by British Columbia:

(a) By June 30, 2011, an annual spending plan for the 2011-12 fiscal year commencing April 1, clearly identifying the planned expenditures (and cash flow by month) required to support the planned activities, initiatives and health care services being delivered through the Interim Health Plan (IHP) and/or the Multi-Year Health Plan (MYHP) as identified in section 5.2 and 5.3 of this Agreement, and not to exceed the total annual funding amount described above;

(b) By March 15 of each year, an annual spending plan for the upcoming fiscal year commencing April 1, clearly identifying the planned expenditures (and cash flow by month) required to support the planned activities, initiatives and health care services being delivered through the IHP and/or MYHP as identified in section 5.2 and 5.3 of this Agreement and not to exceed the total annual funding amount;

(c) During the fiscal year, quarterly reports showing the expenditure of funds, variance explanations against the spending plan, commitments against the spending plan to fiscal year-end and explanations showing how expenditures relate to accountabilities and health care outcomes/deliverables contemplated under the annual IHP and/or the MYHP;

(d) Annual audited financial statements of the FNHS within 120 days of year end; and,

(e) Other reporting as British Columbia may reasonably require from time to time.

Annual Funding Letter and Payment Schedule

(6) Each year British Columbia shall review the updated IHP and the MYHP as identified in section 5.2 and 5.3 of this Agreement and the annual spending plan identified above. Upon completion of this review, British Columbia shall issue to the FNHS an annual funding letter that will include a payment schedule showing how the annual funding amount will be paid by British Columbia to the FNHS.

SCHEDULE 3 – LIST OF FEDERAL HEALTH PROGRAMS

1. Federal Health Programs as of the date of this Agreement comprise the following which are more particularly described in the *Health Canada First Nations and Inuit Health Compendium (2007):*

(1) Children and youth programs (Fetal Alcohol Spectrum Disorder, Canada Prenatal Nutrition Program, Aboriginal Head Start on Reserve, Maternal and Child Health);

(2) Chronic Disease Programs and Injury Prevention (Aboriginal Diabetes Initiative, Injury Prevention);

(3) Primary Care (Community Primary Health Care and Nursing Services, Oral Health Care, First Nations Home and Community Care);

(4) Communicable disease control programs (Vaccine Preventable Diseases (Immunization), Blood Borne Disease and Sexually Transmitted Infections (HIV/AIDS), Respiratory Infections (Tuberculosis, Pandemic Influenza));

(5) Mental Health and Addictions Programs (Building Healthy Communities, Brighter Futures, National Native Alcohol and Drug Abuse);

(6) Environmental Health and Research Programs;

(7) Health Governance/Infrastructure Support (E-health solutions, Aboriginal Health Human Resources Initiative, Aboriginal Health Transition Fund (as replaced by the Health Services Integration Fund in 2010), Health Careers Program);

(8) Health facilities and capital maintenance;

(9) Youth Solvent Abuse Program, National Aboriginal Youth Suicide Prevention Program;

(10) Indian Residential Schools Resolution Health Support; and

(11) The NIHB Program.

2. Only those programs listed in section 1 are Federal Health Programs for the purposes of this Agreement. The Parties acknowledge that certain of the health programs and services or components thereof which are listed in the *Health Canada First Nations and Inuit Health Compendium (2007)* are not included in the Transfer of Federal Health Programs under this Agreement. In particular, programs and services set out in the Compendium which are excluded from the purview of this Agreement include:

a. All programs and services or aspects of programs and services for Métis or Inuit persons;

b. All programs and services that are application-based or not managed by the HC/FNIH Regional Office (such as the Métis, Off-reserve Aboriginal and Urban Inuit Prevention and Promotion program); and

c. All programs and services which are not relevant to British Columbia (including the Labrador Innu Comprehensive Healing Strategy).

SCHEDULE 4 – FNHA CORPORATE GOVERNANCE REQUIREMENTS

The FNHA shall ensure that its constitution, by-laws, policies and procedures will be based on standards that are at least consistent with, and otherwise exceed those set out below, subject to applicable incorporation legislation:

FNHA Corporate organization and separation of functions

(1) The FNHA shall have at least the following corporate and organizational elements and characteristics:

(a) The membership structure shall be representative of and approved by BC First Nations;

(b) The board of directors shall reflect a broad range of skills and experience to enable it to act effectively to fulfill the mandate of the FNHA and shall be chosen by the members pursuant to a formal and transparent nomination and or selection process;

(c) FNHC members may not sit on the FNHA board of directors, though they may be members of the FNHA;

(d) It shall be a condition of directorship on FNHA's board (and as part of the code of conduct of such board), that FNHA directors must act independently and solely in the best interests of FNHA, and that no director may serve the interests of his or her affiliated groups, including, without limitation, the FNHC, unless, in doing so, such director is also acting in the best interests of FNHA and the fulfilment of its mandate on behalf of First Nations in BC;

(e) There shall be public disclosure of directors' per diem allowances, travel expenses and any other remuneration;

(f) Its employees shall be chosen pursuant to a selection process targeting most qualified candidates, and shall be paid reasonable remuneration that is reflective of experience, position and duties fulfilled;

(g) There shall be a clear separation of functions and roles. No one person may simultaneously act as more than one of (i) member (ii) director and (iii) employee; and

(h) The following persons may not serve as directors of the FNHA:

(i) Elected federal, provincial or municipal officials; and

(ii) First Nations health directors.

Planning/Performance/Evaluation

(2) The FNHA shall operate according to the following characteristics and principles regarding its planning, performance and evaluation processes:

(a) The directors shall act on a fully informed basis, in good faith, with due diligence and care, and in the best interest of the organization and its members and stakeholders;

(b) The directors shall approve corporate and operational plans and strategic vision;

(c) Organizational and operational (health) performance goals shall be set and updated; and

(d) There will be an objective evaluation of performance of the directors and monitoring the effectiveness of the FNHA's governance practices.

Budgets / strong financial control / monitoring and audit systems

(3) The FNHA shall have strong internal controls systems, budgeting and allocation processes including as set out in s. 4.2(2) (k) (l) and (m) of the main body of this Agreement.

Conflicts of interest / ethics

(4) The FNHA shall have strong internal conflict of interest and ethical standards, with the following minimums:

(a) a written code of conduct for board of directors and employees (ethics);

(b) a written conflict of interest policy and procedures that ensure that a director does not vote and an employee does not make a decision on a matter in which they have a personal interest; and

(c) policies and mechanisms to monitor compliance.

Accountability and reporting

(5) The FNHA shall have strong internal accountability processes, with the following minimums:

(a) the directors shall be accountable to members; and

(b) all members shall be provided with timely access to relevant information, and, upon request, copies of financial reports, audit findings and a copy of the Canada Funding Agreement.

Risk Management

(6) The FNHA shall institute risk management policies, at least consisting of:

(a) systems for identification and mitigation of risk; and

(b) systems to require and monitor compliance with the law and generally accepted business practices and standards.

SCHEDULE 5 – LIST OF CANADA / FNHA SUB-AGREEMENTS TO BE NEGOTIATED

Canada and the FNHA (for the purposes of this Schedule, the "parties") shall enter into discussions immediately following the signing of this Agreement and the creation of the FNHA with the objective of entering into all further agreements necessary to effect and support the Transfer of Federal Health Programs and the implementation of this Agreement.

The Sub-Agreements will include those set out below and such other agreements as the parties may agree. The Sub-Agreements shall contain at least the terms set out below and such other terms and conditions as the parties agree and which are consistent with law. The Sub-Agreements may also be entered into simultaneously or over time to suit the pace of transfer as may be agreed by the FNHA and Canada.

1 - Human Resources

A human resources agreement or agreements to facilitate the hiring of HC/FNIH Regional Office staff by the FNHA in order to support a smooth transition of operations from Canada to the FNHA in respect of the Transfer of Federal Health Programs.

This agreement will set out provisions for, among other things, a reasonable job offer to full-time and part-time indeterminate employees as per the National Joint Council Work Force Adjustment Directive, where referenced in or incorporated into a collective agreement or a collective agreement itself contains comparable reasonable job offer provisions, or under the applicable Directive on Terms and Conditions of Employment as applicable to the employee.

2 – Health Benefits

A health benefits agreement to provide that the FNHA will design, plan, manage and deliver a health benefits program that replaces the NIHB Program and that includes the actions and commitments required for a smooth transition and to maintain continuity of health benefits services to clients. The health benefits agreement or agreements shall also include provision for:

- the health benefits program of the FNHA to cover all Status Indians who are residents of BC within the meaning of the BC Medical Services Plan, excluding persons who receive health benefits by way of another agreement with Canada;
- the provision by the FNHA of health benefits in the following category areas, in a manner designed by the FNHA that best serves the health needs of Status Indians resident in BC:
    - (a) pharmaceuticals;
    - (b) dental care services;
    - (c) vision care services;

(d) medical transportation, and

(e) medical supplies and equipment health benefits;

- HC and the FNHA to share information on eligible clients and other activities as necessary and in accordance with law in order to manage their respective responsibilities, and for the FNHA and British Columbia to work together to coordinate benefits; and

- the ability of the FNHA, as a transitional measure (and subject to HC obtaining the appropriate authority), to enter into an agreement with Canada whereby Canada would provide health benefits on behalf of the FNHA on a cost recovery basis agreed to by the parties.

3 - Records Transfer, Information Management and Information Sharing

A records transfer and information management and sharing agreement or agreements to facilitate the Transfer of Federal Health Programs. Such agreements shall be subject to and in accordance with applicable laws and privacy impact and threat risk assessments. Such agreements shall include provision for:

- prior to any Transfer of Federal Health Programs to the FNHA, the loan, provision of copies, transfer, or sharing of federal information and records to the FNHA that is consistent with federal legislation prior to the Transfer of Federal Health Programs to the FNHA;

- as part of the Transfer of Federal Health Programs to the FNHA, the loan, provision of copies or transfer of federal information and records to the FNHA and for the management of this information and records by the FNHA in accordance with applicable laws;

- the sharing of information between Canada and the FNHA of personal and non-personal information that is required for the purposes of this Agreement and or the provision of health services to First Nations by Canada and the FNHA in accordance with applicable laws; and

- the FNHA to develop the necessary administrative, technical and physical safeguards for ongoing housing and storage of records as set out in recommendations from Privacy Impact and Threat Risk Assessments prior to entering into the above agreements.

4 - Assets and Software

Asset, software and IP agreements for the assets used by the HC/FNIH Regional Office for the provision of Federal Health Programs and which are owned, leased or licensed by Canada. The parties shall identify and agree on all assets to be transferred (if transferable by Canada). Such transfers shall be subject to applicable laws including the *Financial Administration Act* (Canada) and the *Surplus Crown Assets Act* (Canada). Asset transfer agreements shall include provision for:

- the transfer of computer hardware and software and related supplies and equipment which the parties identify and agree to transfer and where transfer is permitted by applicable lease or licensing arrangements without significant cost or penalty to Canada. Canada will

continue to maintain and replace hardware and software according to established schedules until the effective date of transfer;

- the transfer of other assets including office furniture and supplies, fleet vehicles, and medical equipment located in nursing stations that the parties identify and agree to transfer which Canada can transfer without significant cost or penalty;

- Canada to maintain such assets in good condition, subject to normal usage, wear and tear during the period prior to and until the transfer of the assets to the FNHA. All transfers shall be on an "as is" and "where is" basis without warranty as to fitness. The FNHA shall be responsible for all such assets and their repair or replacement following transfer from Canada; and

- Canada shall remove any assets located in nursing stations or otherwise in buildings to be used by the FNHA which are not to be transferred to the FNHA.

5 - Accommodation

An accommodation agreement or agreements for the subletting or assumption by the FNHA of Crown-owned or leased office space currently occupied by the HC/FNIH Regional Office and used for the delivery of Federal Health Programs ("FNIH Office Space") that the FNHA wishes to assume. Such agreements shall be in accordance with law and shall include provision for:

- the FNHA to be entitled to rent any Crown-owned FNIH Office Space at market rates (space and operating costs) for up to three years, subject to earlier termination within eighteen (18) months notice by either party;

- the FNHA to be entitled to sublet, where possible, any FNIH Office Space that is rented or leased by the Crown;

- consultation by Canada with the FNHA prior to Canada renewing, extending, terminating or otherwise changing an accommodation arrangement for any FNIH Office Space during the period between the signing of this Agreement and the completion of the Transfer of Federal Health Programs;

- leasing or subletting by Canada to the FNHA to be effected on an "as is" basis without warranty as to fitness. However, Canada shall make best efforts to provide the FNHA with information in its possession as soon as possible as to any known and material problems with any lease arrangements to be taken over by the FNHA in view of the likely use of the leased premises by the FNHA, such as pending rent increases or lease termination; and

- the FNHA to be responsible for the FNIH Office Space, and all necessary repairs and renovations, if any, following transfer of these premises to the FNHA via lease or subletting arrangements.

6 - Capital Planning / First Nations Health Facilities:

Agreement on the responsibilities associated with funding the construction, renovation, repair, operation and maintenance of First Nations health facilities including nursing stations, health centres, nurse residences and other health support facilities located on reserve or in or near First Nation communities. Such an agreement shall include provision for:

- the FNHA to develop a health facilities capital plan or planning process which, among other things will allocate resources for current and future facility needs;
- process and procedures of the FNHA to conduct audits of such health facilities for environmental and health and safety issues;
- Canada to provide a copy of the HC/FNIH Regional Office's existing capital plans and a complete list of all current capital contribution projects funded by Canada and associated Canada CA's; and
- Canada to provide the FNHA with a report on the status of any hazardous materials surveys or environmental site assessments completed at any First Nation health facilities, including any such surveys or assessments conducted, their results and any remediation processes funded or undertaken by Canada. In the event of any significant adverse findings in the report, the parties will meet to discuss the matter.

7 - Assignment or Termination of Canada CA's

Agreement between the parties, in respect of the Transfer of Federal Health Programs which involve the funding of First Nation Health Providers, for Canada to assign or novate affected Canada CA's with those providers to the FNHA that would otherwise be in effect on the date of such transfer. Where such assignments or novations are not possible, Canada shall terminate the affected Canada CA's on ninety (90) days notice, so that new contribution agreements can be concluded between the FNHA and First Nation Health Providers.

BRITISH COLUMBIA TRIPARTITE FIRST NATIONS HEALTH
BASIS FOR A FRAMEWORK AGREEMENT ON HEALTH GOVERNANCE

Between
BC FIRST NATIONS
As represented by the First Nations Health Council
And
Her Majesty the Queen in Right of CANADA
As represented by the Minister of Health
And
Her Majesty the Queen in Right of BRITISH COLUMBIA
As represented by the Minister of Health Services and
The Minister of Healthy Living and Sport
("The Parties")

July 26, 2010

This "Basis for a Framework Agreement on Health Governance" has been initialled by the lead negotiators for each of the Parties. It is submitted to the Principals with a recommendation that each Party seek authority to conclude a Framework Agreement based on this document.

Government of Canada

Ian Potter
Health Canada

Government of British Columbia

Andrew Hazlewood
BC Ministry of Healthy Living and Sport

First Nations Health Council

Grand Chief Doug Kelly

Canada

BRITISH COLUMBIA
The Best Place on Earth

Table of Contents

1: INTRODUCTION

While diverse in language, as well as cultural and spiritual practices, historically, First Nations in BC share commonalities in approaches to the health and wellness of their people. The elders, community, and the Nation have always ensured the wellness of their people and next generations through their own governance systems that incorporated traditional knowledge, medicines, values and beliefs. However, in recent history there have been disruptions in these inherent systems. The health status of First Nations is less than British Columbia residents. BC First Nations and the governments of Canada and British Columbia agree that the health system needs to better address the overall health needs of BC First Nations. Today, BC First Nations are working in partnership with the Federal and Provincial governments to address this issue and to improve the health services and outcomes of First Nations people.

In November 2005, the Government of BC, ("the Province"), the Government of Canada, ("the Federal Government") and the political executives of the First Nations Summit, the BC Assembly of First Nations, and the Union of BC Indian Chiefs, signed the Transformative Change Accord (TCA). The TCA established commitments for a 10-year plan to bridge the socio-economic gaps in each of the following four areas: Education, Health, Housing and Infrastructure, and Economic Development. The TCA acknowledged that:

> "...new resources will be required to close the gaps..." and "...recognize[d] the need to examine how existing resources are expended with the view that transformative change will require different funding approaches." (page 2, TCA)

The TCA led to the Transformative Change Accord: First Nations Health Plan (TCA: FNHP) released in November 2006 by the Province and the BC First Nations Leadership Council. As stated in this document:

> "The actions identified in the Transformative Change Accord are necessary but not sufficient to close the health gaps." and "Closing the health gap must also include addressing conditions such as poverty, education, housing, employment and economic opportunities affecting First Nations." (pages 3 and 4, TCA: FNHP)
>
> "There is an opportunity to improve the linkages between health planning at the community level and the regional planning activities of the Health Authorities. First Nations must be more involved in decision-making regarding their health and well-being, and must be involved in health planning, the delivery of health services and the monitoring of health outcomes. First Nations recognize their responsibility and leadership role to improve the health of First Nations individuals, families and communities. In order to support these things, First Nations require improved coordination, processes and mechanisms, and health care services must be provided in a collaborative and coordinated manner so that gaps in health care services can be closed and reciprocal accountability is implemented." (page 5, TCA: FNHP)
>
> "The Province has the responsibility for providing all aspects of health services to all residents of British Columbia, including Status Indians living on and off-reserve. The Federal Government has a financial responsibility to support the delivery of health

services to Status Indians on reserve and pays for Medical Service Plan premiums for Status Indians (page 4, TCA-FNIIP)

The Federal Government joined with the Province and First Nations Leadership Council to build on the TCA: FNIIP by releasing the Tripartite First Nations Health Plan (TFNHP) in June of 2007.

The TFNHP states:

"First Nations health services will be delivered through a new governance structure that leads to improved accountability and control of First Nations services by First Nations." (pg. 2, TFNHP)

"The Parties will discuss potential changes to programs and services (including the transfer of programs and services) that might impact on other Parties." (page 3, TFNHP)

"All Parties to this Plan will contribute financially and/or in kind to the implementation of the new First Nations health service governance and delivery structures and other elements of the Plan, based on mandates, available resources and authorities." (page 4, TFNHP)

It is envisioned that the new health governance structure will consist of four components, a First Nations Health Council (FNHC), a First Nations Health Directors Association (FNHDA), a Provincial Committee on First Nations Health, and a new First Nations Health Authority (FNHA).

This commitment recognizes the importance of First Nations decision-making in the design and delivery of health services for First Nations peoples and the need to evolve the "Province's and the Federal government's roles to governance partners and funders." (page 2, TFNHP). The Parties confirm that BC First Nations governance over their own health will assist in the improvement of the health status of their people, and therefore, the new arrangement will not diminish this but will ensure it is recognized, respected and supported.

BC First Nations will work through a First Nations designed health governance structure to enact policies, measure success, allocate resources, and establish service standards for First Nations peoples in BC. BC First Nations will have direct influence and decision making over programs, services, functions and activities transferred from Health Canada to the FNHA.

This Basis for a Framework Agreement on Health Governance (the "Basis Agreement") provides the basic commitments and processes necessary to develop a new administrative arrangement for the delivery of existing federal health services that uniquely reflects the cultures and Indigenous perspectives of BC First Nations and that is founded on a First Nations definition of health and wellness.

BC First Nations will bring forward a perspective of wellness to address the health of their people rather than a focus only on treatment once people have developed health issues. The wellness perspective will incorporate a holistic approach that will look at ensuring First Nations people achieve a healthy balance in the four aspects of their lives as described in the medicine wheel: mental, spiritual, emotional, and physical well-being. To achieve this,

BC First Nations will work to implement health initiatives that will include proactive measures to address health promotion and injury and disease prevention as well as contributing to the advancement of positive change for First Nations in relation to the social determinants of health such as education, housing, and economic development.

The Parties will continue to be engaged in tripartite negotiations to further develop, identify, and outline the commitments, and processes necessary for the creation of a new FNHA, and the other three components of the new First Nations health governance structure, consistent with the vision, principles, and objectives identified in the TFNHP.

The new First Nations health governance structure will support the development of an integrated health system in British Columbia, in which BC First Nations, will be "...fully involved in decision-making regarding the health of their peoples." (Page 1, TFNHP). Under this new system, the Federal Government will evolve from a designer and deliverer of health services to that of a funder and governance partner, and BC First Nations, the Province, and the Health Authorities will work more closely to ensure that federally and provincially funded health programs and services will be better coordinated and will more effectively meet the needs of BC First Nations.

This new governance structure will work within the legal framework for health in British Columbia.

2: GENERAL PROVISIONS

2.1 PURPOSE

This Basis Agreement sets out the description of the elements, mutual undertakings and processes that will form the foundation for the negotiations of a British Columbia Tripartite First Nations Framework Agreement on Health Governance (the "Framework Agreement") between the Federal Government and the Province and the First Nations of British Columbia.

The Parties intend for the Framework Agreement to:

- Uphold and build upon the outcomes as agreed upon in the TCA:FNIIP and TFNHP;
- Be used as a framework to create a new health governance structure;
- Clarify the relationship and commitments between the Federal Government and the Province and BC First Nations in the areas of health;
- Clarify how the Parties will work together to develop processes to better address the social determinants of health for First Nations in BC;
- Set out the roles and responsibilities of the FNHA which will work in partnership with the Provincial Ministries of Health and the Health Authorities to create a more integrated seamless health system that better meets the needs of First Nations.
- Provide for the transfer of the policy and service delivery role currently undertaken by the Federal Government to BC First Nations to operate and to form new partnerships with the Health Authorities. It will set clear targets and milestones for that transition;
- Set out the main commitments for the transfer of federal funding to First Nations to support the federally transferred programs and services that include: community programs (including the retained sunsetting programs), NIHB, capital, policy and

program leadership, management and administrative services; support to the Tripartite First Nations Health Plan; and contains provisions for a ten-year agreement with an annual escalator that is established for the first five (5) years; and

- Recognize that there will be subsequent agreements detailing specific bilateral commitments.

2.2 PRINCIPLES

The Parties acknowledge and uphold the agreed upon set of principles identified in the TFNHP. These principles as well as those stated below will guide the formulation of the commitments and processes to be set out in the Framework Agreement.

a) Respect and Recognition:

- The Parties recognize the need for BC First Nations to be able to govern their health.
- A new First Nations health governance structure will be founded on the recognition that BC First Nations governance in health requires having direct input and decision making in health matters through a nation-based approach.
- The Parties acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities, and will seek to remove impediments to progress by establishing effective working relationships (page 2, TFNHP).
- The Parties recognize that First Nations' models of wellness, which include cultural knowledge, values and traditional health practices and medicines, will enhance First Nations health and the health care system.

b) Governance and Partnerships:

- The Parties acknowledge that First Nations have the authority to design and deliver health services at the community level and that First Nations are governance partners. The Parties understand governance to refer to certain administrative arrangements established as a result of the implementation of the TFNHP under which BC First Nations manage a system for First Nations health services.
- Health services will generally be delivered at local or community levels unless economies of scale and aggregated services are necessary through collaborative arrangements at a regional or provincial level to address issues such as population health matters.
- The role of Health Canada will shift from a designer and deliverer of health services to a funder and governance partner.
- The Province will continue to be a funder of the TFNHP and a governance partner as well as a continued provider of provincial health services.

- The Parties will continue to develop effective governance partnerships, including with the Health Authorities (HAs), for matters relating to First Nations' health.

- Information will be shared between Parties in an open and timely manner, subject to and in accordance with the law (page 3, TFNIIP)

c) Strengthening and Restoring Health and Well-being:

- The Parties recognize that a new governance structure for the planning, management and delivery of health services for BC First Nations is intended to lead to improvements in the quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health services, programs and services for BC First Nations peoples.

- 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.

- The Parties recognize that health programs and services are only one of the determinants of health and agree that the way forward will require joint commitments to deal with the social and economic determinants.

d) Accountability:

- The new health governance structure will be based on reciprocal accountability of the Parties, as well as a commitment to transparency, credibility, and collaboration as described in Sections 7 and 8 of this Basis Agreement. Reciprocal accountability is described in the TFNIIP as "each Party will be responsible to the others for obligations and commitments under this Plan" and relates to all of the agreements (TCA-FNIIP, FNHP-MOU, TFNHP and Framework Agreement).

2.3 GOALS

The Parties continue to work toward the shared vision identified in the TFNHP with the understanding that this vision recognizes, respects, and upholds the purpose and principles as identified in this Basis Agreement. For greater certainty, the Province and BC First Nations reiterate and reconfirm their commitments as set out in the TCA: FNIIP and the Parties reiterate and reconfirm their commitments as set out in the FNHP-MOU and TFNHP. The Parties recognize the vision to include the following goals:

a) To create a new First Nations health governance structure that will result in a better more integrated and responsive health system with reduced jurisdictional obstacles to continuity of care. The new structure will deliver quality services and support equitable access for First Nations in British Columbia. Duplication will not occur and a parallel health service delivery structure will not be created;

b) To continue working in partnership to meet the purpose, vision, and targeted outcomes identified in the TFNHP;

c) To assist First Nations, through the new health governance structure, with their responsibilities and efforts to improve the provision of health services through providing support for First Nations communities to develop and implement community health and wellness plans;

d) "First Nations in all regions of British Columbia will have access to quality health services comparable to those available to other Canadians living in similar geographic locations." (Page 2, TFNHP); and

e) To ensure "...prevention and primary health services on-reserve [are] improved so that they meet or exceed those services provided off-reserve." (Page 14, TCA: FNHP)

2.4 NO PREJUDICE

This Basis Agreement and the Framework Agreement are not intended to have the effect of, or be interpreted as:

a) Recognizing, affirming or denying, any Aboriginal or Treaty Rights of First Nations;
b) Abrogating or derogating from (i) any existing aboriginal and treaty rights of First Nations; or (ii) the application and operation of section 35 of the *Constitution Act 1982* to such rights;
c) Ending or altering the evolving fiduciary relationship between the Crown and BC First Nations;
d) Altering any responsibilities of the federal and provincial governments for First Nations health (except to the extent that the means of discharge of any such responsibility may change in accordance with the laws of Canada and/or British Columbia in respect of the planning, managing and delivering of health care programs and services on behalf of BC First Nations people under or as a result of this Agreement); or
e) Modifying any treaty or creating a new treaty within the meaning of the *Constitution Act, 1982*.
f) Prejudicial to any applications, court actions, negotiations or settlements with respect to land claims or land entitlements involving any of the BC First Nations; and
g) Prejudicial to the implementation of any inherent right of self-government or any agreements that may be negotiated with respect to self-government with and of BC First Nations.

The Parties acknowledge that the arrangements entered into under this Basis Agreement are not intended to determine, delineate, or define:

a) The distribution of powers between the Federal Government and the Province in relation to health; or
b) The scope of federal jurisdiction under section 91(24) of the *Constitution Act*.

3: ESTABLISHING A NEW GOVERNANCE STRUCTURE FOR FIRST NATIONS HEALTH

Health governance refers to BC First Nations having direct influence and decision-making in the design and delivery of their health programs and services.

A new First Nations health governance structure will support health services to be delivered at local or community levels. When economies of scale and aggregated services are necessary, services will be delivered through collaborative arrangements at a regional or provincial level to address matters such as population health.

3.1 CONTINUING COMMITMENT

The Parties confirm that they are committed to continue working together and to take the necessary steps through a staged approach to seek the establishment of a new governance structure for First Nations health services in British Columbia.

The Parties agree that the establishment of a new health governance structure, and the components within, will adhere to and uphold the agreed upon principles outlined in this Basis Agreement.

The Federal Government agrees to an annual meeting between the First Nations Health Council and Indian and Northern Affairs Canada's Quality of Life table and an annual meeting between the First Nations Health Council and the Federal Interdepartmental Committee on Aboriginal Issues which would serve to influence the work of Federal Deputy Ministers responsible for health and social determinants of health matters.

The Province agrees to an annual meeting between the First Nations Health Council and the Deputy Minister's Committee on Recognition and Reconciliation.

This commitment of the federal and provincial governments to invite the FNHC to annual meetings of their respective Committees cited above will extend as well to any new committee created to replace them and whose mandate is to address health and social determinants of health matters.

The FNHA will provide technical support for the FNHC at these aforementioned meetings, and the FNHDA will be included when deemed necessary.

3.2 GOVERNANCE

The components of the new governance structure will include:

a) A First Nations Health Council (FNHC);
b) A First Nations Health Directors Association (FNHDA);
c) A Provincial Committee on First Nations Health; and
d) A First Nations Health Authority (FNHA).

These organizations will work in collaboration with other health service providers including First Nations and their designated health organizations, Health Authorities and other federal and provincial departments and agencies.

The Parties recognize that all components of the new governance structure need to be supported to play an effective role in the overall health system in BC.

3.2.1 First Nations Health Council (FNHC)

BC First Nations have taken steps to create an interim FNHC that is accountable to First Nations leadership and communities. The final form of the FNHC will be determined by BC First Nations leadership, which may include transforming to a regional representative model to potentially provide a voice from BC First Nations from all regions of the province and First Nations peoples on and off reserve.

The role of the FNHC will be:

a) Supporting and assisting First Nations in achieving their health priorities and objectives;
b) Advocacy for BC First Nations on health issues and health services;
c) Supporting First Nations and their designated health organizations in policy analysis and research;
d) Providing a First Nations leadership perspective to policy and program planning processes related to First Nations health; and
e) Providing continued leadership for the implementation of the Transformative Change Accord: First Nations Health Plan and the Tripartite First Nations Health Plan.

3.2.2 First Nations Health Directors Association (FNHDA)

BC First Nations have begun the work to create a FNHDA with a structure and mandate developed by the directors of First Nations health organizations with the support of the FNHC. BC First Nations will complete this work and establish the FNHDA.

As part of the First Nations health governance structure, the Parties intend that the FNHDA will:

a) Represent the health managers and professionals working in First Nations health organizations;
b) Support education, professional development and standards;
c) Act as an advisory body to the FNHC and FNHA on professional and administrative issues; and
d) Provide advice and insight to policy, program planning and design processes.

3.2.3 Provincial Committee on First Nations Health

The Parties will undertake the necessary steps to evolve the Provincial Advisory Committee on First Nations Health into a Provincial Committee on First Nations Health (PCFNH). The PCFNH would include representatives from provincial ministries of Health, Health Canada,

Health Authorities, the FNHA, the FNHC and other members as agreed upon such as representation of the FNHDA or other health partner groups.

The Parties intend that the PCFNH will:

a) Coordinate planning, programming, and service delivery of the FNHA with Health Authorities (HAs) in support of First Nations Community Health and Wellness Plans;
b) Establish reciprocal accountabilities between BC First Nations and the HA's to ensure HA's work with and collaborate with BC First Nations in their respective regions to develop and review their plans and strategies for Aboriginal and First Nations people;
c) Facilitate discussions and coordinate planning and programming between BC First Nations, the Province, and the Federal Government on all matters relating to First Nations health and wellness, including other determinants of health; and
d) Provide a forum for discussion on the measures of reciprocal accountability for the parties with respect to all the agreements (TCA-FNIIP, FNIIP-MOU, TFNHP and Framework Agreement); and
e) Prepare an annual report for the Ministers of Health and the First Nations Health Council.

3.2.4 First Nations Health Authority

The overall governance structure of the FNHA will be determined by BC First Nations and will be reflective of a nation-based approach to decision making. BC First Nations will work together to drive the overall strategic direction of the FNHA and establish reciprocal accountability measures to define an effective and responsive working relationship between BC First Nations and the FNHA.

BC First Nations will take the necessary steps to incorporate the FNHA as a legal entity under the *Canada Corporations Act* or any successor legislation. Appropriate legal status is deemed important to ensure the FNHA has the powers, authority, and securities necessary to achieve its evolving role and mandate as described in this Basis Agreement.

The Parties agree that the FNHA, including its Board and membership, will be established and will operate consistent with the following principles:

a) Be representative of BC First Nations;
b) Be accountable to BC First Nations;
c) Respect nation-based and community driven principles of BC First Nations;
d) Recognize the importance to individual BC First Nations of their governance role in addressing the health of their communities;
e) Provide for a clear distinction around and between the political and business processes for running the FNHA;
f) Work with BC First Nations where they are at in terms of their governance of health care and the delivery of health services;
g) Be transparent, accountable, and credible;
h) Work in partnership with the Federal Government and the Province, HAs and other components of the new health governance structure to improve health outcomes and wellness for BC First Nations;

i) Uphold reciprocal accountability measures with federal and provincial partners;
j) Optimize resources at a community level;
k) Enhance collaboration among First Nations health providers and other health providers to address economies of scale service delivery issues to improve efficiencies and access to health care;
l) Work with partners to address gaps in health services so that First Nations have equitable access, to quality, culturally appropriate health services (page 9, TCA:FNHP);
m) Work in partnership with the Federal Government, the Province, and HAs, to integrate First Nations models of wellness into the health care system;
n) Operate in a manner that no BC First Nation would be left behind; and
o) Use the following characteristics of a high performing board, as identified by the Institute on Governance, as a guide to create model governance policies and tools:
    i. Develop and maintain a longer term vision and clear sense of direction
    ii. Ensure prevalence of high ethical standards
    iii. Ensure effective performance through sound information
    iv. Ensure financial and organizational health
    v. Ensure sound relationships with key external bodies
    vi. Ensure sound relationships with their members, clients
    vii. Manage risk effectively
    viii. Are accountable
    ix. Ensure soundness of governance system

4: ROLES AND RESPONSIBILITIES OF THE FNHA

4.1 ROLE OF THE FNHA

The Parties intend that the role of the FNHA will initially involve taking over the programs, services functions and activities of the First Nations Inuit Health (FNIH) BC region as well as some FNIH Branch and headquarters roles, activities, and functions. The FNHA will work in partnership with the Province and Health Canada to implement the health action items in the TFNHP.

Transitional measures will be developed by the Parties, which will include joint management provisions and a phased approach over an agreed upon period of time.
The Parties intend that the FNHA will:

a) Incorporate and promote First Nations knowledge, beliefs, values, practices, medicines, and models of health and healing into the health programs and services for BC First Nations;
b) Honour and respect all existing contribution agreements between Health Canada and BC First Nations or their mandated health organizations;
c) Support First Nations and their designated health organization to plan, manage, organize and otherwise carry out their responsibilities and authorities to deliver health services to their communities;
d) Work to ensure "...prevention and primary health services on-reserve [are] improved so that they meet or exceed those services provided off-reserve." (pg 14, TCA: FNHP).

e) Continue to provide programs, services and functions as currently provided by the FNIH BC region to BC First Nations in the interim to ensure continuity and minimal disruption to the existing level of support to BC First Nations;
f) Facilitate and support capacity for First Nations communities to work with the FNHA to improve access to appropriate health services through collaborative planning and decision making, and the establishment of comprehensive community health and wellness plans;
g) Over time, modify, redesign, or transform the federal programs, services, functions and activities, through a collaborative and transparent process with the BC First Nations to better meet First Nations health and wellness needs. Any changes that may impact existing contribution agreements will require the approval of the First Nation impacted;
h) Work in partnerships with the Provincial ministries of Health and the Health Authorities;
i) Provide First Nations program and policy advice to the provincial and federal health departments, service providers, and agencies;
j) Provide direct support and service delivery for First Nations health and wellness matters at a population health level, and other areas as agreed to by the Parties and BC First Nations;
k) Collect and maintain clinical information and patient records and to develop protocols with the Health Authorities for the sharing of patient records, consistent with the law, and to better serve First Nations patients;
l) Generate, collect, and enable greater First Nations control over the use, collection and access to health data relevant for the improvement of health services and necessary to monitor and report on First Nations health in BC;
m) Establish standards for health services provided by the FNHA that meet or exceed generally accepted standards;
n) Develop policies and strategies that promote a First Nations wellness system;
o) Work with BC First Nations at a regional level to establish a collaborative health table, forum or institution to reflect their collective authority and to enter into agreements and partnerships with Health Authorities to coordinate programs and services to better serve First Nations as determined by First Nations;
p) Work with educational institutes and regulatory bodies to promote training of First Nations people, adapt education plans and curriculums to better serve First Nations, and encourage health and wellness research that will benefit First Nations; and
q) Work with health professional colleges or associations to support or adapt their standards and practices so as to meet the needs of First Nations;

The FNHA will establish new relationships with Health Canada, other departments in the Federal Government, the Province, provincial ministries of Health, and Health Authorities. These relationships and roles will:

a) Enhance the First Nations opportunities to work with relevant government departments and agencies and their executive staff to improve the health outcomes of BC First Nations;
b) Enhance the FNHA's ability to build multi-sectoral partnerships to better address the social determinants affecting the health status of First Nations;
c) Continue the on-going discussion on the transfer of agreed upon responsibilities and authorities to the FNHA in respect to programs, services, functions and activities to address First Nations Health matters; (Page 3, TFNHP)

d) Facilitate data collection, monitoring, and reporting on First Nations health, including the development of First Nations determined indicators of wellness, by the FNHA, the Province and the Federal Government; and,
e) Establish clear relationships with provincial ministries (including Health Authorities) to support BC First Nations to create partnerships with Health Authorities to ensure services are delivered with direct input by BC First Nations.

4.2 EVOLVING ROLE OF THE FNHA

During the implementation of the FNHA, it is intended that the roles and responsibilities of the FNHA, through its federal and provincial partnerships, will continue to evolve and will be responsive to the needs, interests and priorities of BC First Nations. In particular, the FNHA will continue to work with Health Canada to address First Nations health matters as part of Health Canada's national First Nations health responsibilities.

The Parties recognize that reciprocal accountability framework meetings will take place regularly between the Parties to assess the effectiveness of this partnership and discuss potential changes to roles, powers, or funding that may be required. For example, the FNHA will work to expand its role in Public Health including areas such as water and waste water management.

5: TRANSFER OF FEDERAL PROGRAMS, SERVICES, AUTHORITIES AND FUNCTIONS

5.1 PROGRAMS

The Parties recognize that the transfer of the federal programs, services, and/or functions, including direct and indirect costs, requires the provision of adequate and sustainable funding to the FNHA.

5.1.1 Programs to be Transferred

The Federal Government agrees to transfer the following programs, operations and management and their related support services, functions and activities, to the control of the FNHA within two years of the signing of the Framework Agreement. These programs listed below include the FNIH programs of the BC regional office, Capital and the related headquarter programs and activities that provide federal health services or support to BC First Nations:

a) Children and youth programs (Fetal Alcohol Spectrum Disorder, Canada Prenatal Nutrition Program, Aboriginal Head Start on Reserve, Maternal and Child Health);
b) Mental Health and Addictions Programs (Building Healthy Communities, Brighter Futures, National Native Alcohol and Drug Abuse, Youth Solvent Abuse Program, National Aboriginal Youth Suicide Prevention Program, Indian Residential Schools Resolution Health Support);
c) Chronic Disease Programs and Injury Prevention (Aboriginal Diabetes Initiative, Injury Prevention);
d) Primary Care (Community Primary Health Care and Nursing Services, Oral Health Care, First Nations Home and Community Care);

e) Communicable disease control programs (Vaccine Preventable Diseases (Immunization), Blood Borne Disease and Sexually Transmitted Infections (HIV/AIDS), Respiratory Infections (Tuberculosis, Pandemic Influenza);
f) Environmental Health and Research Programs;
g) Health Governance/Infrastructure Support (E-health solutions, Aboriginal Health Human Resources Initiative, Aboriginal Health Integration Fund, Health Careers Program);
h) Non Insured Health Benefits Program; and
i) Health Facilities and Capital Maintenance.

5.1.2 Non-Insured Health Benefits (NIHB) Program

The Federal Government and the Province agree that the Non-Insured Health Benefits program for First Nations in British Columbia will be transferred to the control of the FNHA at a time mutually agreed upon and subject to a detailed transfer agreement negotiated by the Implementation Committee described in Section 11.1.

The Federal Government agrees that the FNHA will have the authority to consolidate, amend, integrate, or vary the policy, program and administrative provisions of the program as it sees fit while continuing to offer a program to support the access of First Nations individuals living in BC to pharmaceuticals, dental services, vision services, medical transportation, and medical supplies and equipment.

BC First Nations agree that on accepting the transfer of the NIHB program that they will be responsible for the provision of the services noted above to all First Nations residents of BC.

The Parties agree to negotiate, as part of the NIHB transfer agreement identified above, the manner and process for coordination of the benefits, provisions and administration of the First Nations program or programs with similar federal or provincial programs.

5.2 BC FNIH OPERATIONS

The Federal Government and the FNHA will pursue discussions with the objective of entering into agreements to address their respective roles and responsibilities related to the transfer of the FNIH operations to the FNHA. These agreements will include the following:

a) An Accommodation Agreement that will describe the terms and conditions following a decision made by the FNHA to remain in any Crown-owned or leased office space currently occupied by Regional staff of Health Canada;
b) A Records Transfer Agreement and a Special Information Sharing Agreement that will set out the provisions for records transfer, including privacy impact, consistent use, information sharing, protection of personal information, etc.);
c) A process and procedures for the conducting the audits of all health facilities for environmental or health and safety issues;
d) An Information Technology and Information Management (IT/IM) agreement that will set out the provisions and process for transfer of agreed upon IT/IM infrastructure and services from Health Canada to the FNHA;
e) A Human Resources Transfer Agreement setting out the provisions for a reasonable job offer to full-time and part-time indeterminate employees as per the application of the federal government workforce adjustment guidelines; and

f) An Agreement on the responsibilities associated with the operation and maintenance of health facilities and nurses' residences in BC, including their renovation according to a health facilities capital plan.

The Parties agree that measures will be taken to ensure a smooth transition that will result in continuity and minimal disruptions, if any, in service provision to BC First Nations. This will include establishing continuity in staff and program delivery processes during the transition period.

6. FEDERAL FUNDING

The Federal Government is prepared to negotiate the following funding transfers, to be paid subject to and in accordance with the following funding agreements and processes:

6.1 TEN (10) YEAR FEDERAL FUNDING AGREEMENT

(1) **General:** The Federal Government will transfer an "Annual Federal Amount" to the FNHA under a "Federal Funding Agreement". The Annual Federal Amount will be calculated in accordance with subsection 6.1(3). The Annual Federal Amount will be paid upon and for the transfer of the programs, services and operations set out in section 5 of this Basis Agreement. The Annual Federal Amount will be paid toward all of the costs to be incurred by the FNHA for the delivery of its Multi-Year Health Plan, inclusive of all related corporate and administrative expenses of any kind including employee pay and benefits, policy and program costs including those in subsection 6.1(7).

(2) **Term:** The Federal Funding Agreement will have a term of 10 (ten) years with funding amounts, program delivery and reporting functions organized on an April 1-March 31 "fiscal year" basis. The Federal Funding Agreement may be entered into at once or in stages at any time following the signing of the Framework Agreement for all or part of the Annual Federal Amount, on such date or dates to be determined by the Federal Government and the FNHA. However, the entire Annual Federal Amount and responsibility for all programs set out under section 5 of this Basis Agreement will be transferred within two years of the signing of the Framework Agreement.

(3) **The Annual Federal Amount:** The Annual Federal Amount shall be calculated as follows.

(a) In the initial fiscal year of the Federal Funding Agreement, the Annual Federal Amount will be equal to the Base Year Amount set out in subsection 6.1(4) as adjusted under subsection 6.1(5).

(b) In fiscal years two (2) three (3), four (4) and five (5) of the Federal Funding Agreement, the Annual Federal Amount will be the prior year's Annual Federal Amount (expressed on an annualized basis in the event of prior partial fiscal years) multiplied by the Annual Escalator set out in subsection 6.1(6).

(c) In fiscal years six (6) through ten (10) of the Federal Funding Agreement, the Annual Federal Amount will be the prior year's Annual Federal Amount multiplied by a new Annual Escalator to be determined by the Federal Government and the

FNHA. If negotiations for a new Annual Escalator for fiscal years six (6) through ten (10) are not concluded before the fifth anniversary of that agreement, the FNHA will receive an Annual Federal Amount for the sixth fiscal year and subsequent fiscal years that it is equivalent to the fiscal year five (5) Annual Federal Amount. The two parties may continue negotiations on the escalator until the expiry of the Federal Funding Agreement and if negotiations are concluded before then, a retroactive adjustment will be made for each of the fiscal years six (6) through ten (10) of the Federal Funding Agreement to pay the FNIIA any differences, without interest, resulting from application of the new Annual Escalator.

(d) If the Federal Funding Agreement takes effect on a date other than April 1, it will have partial initial and final fiscal years. The Annual Federal Amount for any partial fiscal years will be the amount that otherwise applies under this subsection and proportionally reduced by multiplying it by the number of days it will be paid in that fiscal year and dividing by 365.

(4) **Base Year Amount:** The "Base Year Amount", which has been calculated with reference to the total direct, indirect, support and administrative costs of the Federal Government for funding, providing and administering all federal health programs and services for First Nations in the province of British Columbia described in section 5 is the "2008/9 amount" of $318,832,400 as set out in Schedule "A" plus the Adjustment Factor set out in subsection 6.1(5)

(5) **Adjustment Factor:** The 2008-09 amount in subsection 6.1(4) will be adjusted to the effective date of the transfer of the federal programs to the FNHA to become the Base Year Amount by way of the following ("Adjustment Factor"):

(a) the portion of the 2008/9 amount representing NIHB expenditures ($139,077,700) will be replaced by: (i) $154,881,200 if the transfer occurs in fiscal year 2010-11; or (ii) $ 163,455,600 if the transfer occurs in fiscal year 2011-12 or (iii) $172,511,700 if the transfer occurs in fiscal year 2012-13; plus

(b) the portion of the 2008/9 amount representing Regional Community Program Expenditures ($169,413,900) will be replaced by: (i) $175,212,800 if the transfer occurs in fiscal year 2010-11; or (ii) $178,234,900 if the transfer occurs in fiscal year 2011-12 or (iii) $181,378,300 if the transfer occurs in fiscal year 2012-13; plus

(c) the portion of the 2008/9 amount representing Capital expenditures ($10,340,800) will be replaced by: (i) $10,662,000 if the transfer occurs in fiscal year 2010-11; or (ii) $10,829,800 if the transfer occurs in fiscal year 2011-12 or (iii) $10,998,000if the transfer occurs in fiscal year 2012-13.

(6) **Annual Escalator:** The Federal Funding Agreement will provide for fixed annual increases ("Annual Escalator") of 5.5% to the prior fiscal year's Annual Federal Amount (annualized) in fiscal years two (2), three (3), four (4) and five (5) of the Federal Funding Agreement provided that, and during the time that, the NIHB program is included in the programs transferred to the FNIIA under section 5. For any period of time during the above-noted fiscal years that the NIHB program is not included in the programs transferred to the FNIIA, the Federal Funding Agreement will provide for fixed annual increases of 4.5%

to the prior year's Annual Federal Amount (annualized). The Federal Government and the FNHA will commit to negotiate an Annual Escalator for the remaining fiscal years of the Federal Funding Agreement in accordance with subsection (3)(c) and 10(a).

(7) **Multi-Year Health Plan:** The FNHA will prepare a "Multi-Year Health Plan" that sets out its goals, priorities, program plans and anticipated allocation of resources and use of funding to be provided by the Federal Government under the Federal Funding Agreement. The Multi-Year Health Plan will be amended from time to time. Copies of the Plan will be made public and available to the Minister. Without limiting the generality of the foregoing, the Annual Federal Amount may be used by the FNHA, subject to its Multi-Year Health Plan, to fund or to support:

(a) the design and delivery by the FNHA of the transferred health programs, services and operations in a manner to be determined by the FNHA under its Multi-Year Health Plan in order to best serve the health needs of BC First Nations;

(b) administrative, policy and program support and leadership by the FNHA for the transferred programs and services and for their development and design or re-design by the FNHA;

(c) management and corporate services of the FNHA.

(8) **Funding Flexibility:** The Federal Funding Agreement will provide for flexibility in the allocation of resources and in the design and prioritization of programs. The Annual Federal Amount will not be reduced by any of the following:

(a) **Surplus funds / Carry-over:** The FNHA may retain and carry-over surpluses from any fiscal year for use in any subsequent fiscal year during the term of the Federal Funding Agreement for health programs and services in accordance with the FNHA's Multi-Year Health Plan;

(b) **Block Funding / Sun-setting:** The Annual Federal Amount shall be provided as block funding. The FNHA may re-design, re-prioritize or cancel any programs within this block. In the event an ongoing program or service set out in section 5.1.1 of this Basis Agreement terminates or is cancelled by the Federal Government nationally or regionally, there will be no deduction to the funding provided to the FNHA, and any related funds may be retained by the FNHA for investment in health programs and services in accordance with its Multi-Year Health Plan (certain funding including that referred to in sections 6.2, 6.4 and 6.5 are not part of the Annual Federal Amount and may sunset and will continue only to the end of the program or as set out herein); and

(c) **Funding from Other Sources:** Funding provided in relation to a health program or service for which the FNHA may obtain additional funding from sources other than the Federal Government may be retained by the FNHA for that program or service as required or for investment in other health programs and services in accordance with the FNHA's Multi-Year Health Plan.

(9) **Reporting:** The FNHA will:

(a) prepare an annual report for its members, in respect of the Federal Funding Agreement that will be available to the Federal Government and the public. The annual report will report on the FNHA's plans for the coming fiscal year and its activities, expenditures, achievements, and challenges of the previous fiscal year. The annual report will identify the Annual Federal Amount;

(b) Provide for the preparation of an independent evaluation of its plans and programs every five years. This evaluation will be available to its members, the public, and to the Federal Government.

(10) **Renewal Procedures:** The Parties will review the funding and other provisions of the Federal Funding Agreement during its term as part of their regular review of that agreement and will plan for the update and renewal of that agreement as follows:

(a) **Initial Five (5) Year Review:** The Federal Government and the FNHA will review the general and specific provisions of the Federal Funding Agreement and will hold discussions to negotiate the value of the Annual Escalator for the fiscal years six (6) through ten (10) of the Federal Funding Agreement during the fourth fiscal year of the initial Federal Funding Agreement.

(b) **Ten (10) Year Reviews:** For successor agreements to the initial Federal Funding Agreement, renewal negotiations will commence no later than one year prior to the expiry date of the initial or then current Federal Funding Agreement. If negotiations on the new agreement including its funding provisions are not concluded before the prior Federal Funding Agreement expires, the Federal Government and the FNHA agree that for a period of two years they will enter into a new funding agreement, to be negotiated in accordance with section 6.6, with substantially the same terms and conditions as the prior agreement and at a funding level that matches the Annual Federal Amount for the last fiscal year of the prior agreement (expressed on an annualized basis in the event that the final fiscal year is partial).

6.2 IMPLEMENTATION FUNDING

(1) The Federal Government will offer to contribute funding support for implementation and transition costs of the First Nations Health Society (FNHS) required to establish the FNHA and its operations and to transition programs, services, and functions to its management. The Federal Government will offer to provide a one-time payment or payments of up to $17 million to the FNHS to contribute to such costs upon or following the signing of the Framework Agreement and pursuant to a funding agreement or agreements to be negotiated by the Federal Government and the FNHS in accordance with section 6.6

6.3 NEW PROGRAMS AND SERVICES FUNDING

(1) The FNHA may apply for federal funding for any new health or related programs and services which may be introduced by the Federal Government from time to time on a national or regional basis where the FNHA is eligible to receive such funding according to program terms and conditions and where it has the program capacity to undertake all program and service requirements.

(2) Additional funding will not be provided in respect of: (a) new federal programs, services or operations which substantially replace any programs, services or operations set out in section 5 of this Basis Agreement or for which funding has already been provided under an agreement between the Federal Government and the FNHA; or (b) national or regional funding changes for federal programs, services or operations set out in section 5 of this Basis Agreement or for which funding has already been provided under an agreement between the Federal Government and the FNHA;

(3) Notwithstanding subsection 6.3(2), in the event that the Federal Government introduces expanded beneficiary eligibility and associated funding for any federal health programs and services set out in section 5 as a result of possible legislative amendments to the *Indian Act* to increase the number of persons eligible to be registered as an Indian under that Act, the Federal Government and the FNHA will work together to determine impacts and approaches to address such change. The FNHA will be eligible to apply for any new expanded programs, services and associated funding made available nationally by the Federal Government.

6.4 INDIAN RESIDENTIAL SCHOOLS PROGRAM FUNDING

The Federal Government will offer to provide funding to be paid on a time limited basis (not to exceed the duration of the IRS program) pursuant to a funding agreement or agreements to be negotiated between the Federal Government and the FNHA for the purpose of delivering the federal Indian Residential Schools (IRS) Program. Such funding will be provided pursuant to a funding agreement or agreements to be negotiated by the Federal Government and the FNHA in accordance with section 6.6

6.5 TOP-UP FUNDING FOR THE TFNHP

The Federal Government will offer an additional annual contribution to the FNHA to be paid on a time limited basis, and if required, to ensure that the value of the federal contribution to the TFNHP in each year full fiscal of the Federal Funding Agreement is $10 million. The base amount for the TFNHP which is included in the Base Year Amount, is $6 million in 2008-9 fiscal year funds. When that amount, as adjusted by the applicable Adjustment Factor in subsection 6.1(5) and the Annual Escalator in subsection 6.1(6), reaches $10 million, the top-up will cease. Such top-up funding will be provided pursuant to a funding agreement or agreements to be negotiated by the Federal Government and the FNHA in accordance with section 6.6

6.6 FUNDING AGREEMENTS – GENERAL TERMS AND CONDITIONS

(1) Each funding agreement to be entered into by the Federal Government and the FNHA or the FNHS pursuant to the Framework Agreement will, unless otherwise set out herein or agreed in writing:

(a) contain such terms and conditions as the two parties may negotiate provided that such terms and conditions, and the manner of payments to be made under the agreement, are consistent with federal Treasury Board policy and applicable laws;

(b) require preparation by the FNHA or the FNHS of a health plan or spending plans for the funding where applicable (including the Multi-Year Health Plan for the Federal Funding Agreement); compliance by the FNHA with such plans and the funding agreement; reporting of funding spent; and will contain audit provisions as set out in subsection (3);

(c) contain reporting provisions to members and the Federal Government; and

(d) contain provisions that the funding provided is subject to there being a sufficient unencumbered balance of an appropriation made by the Parliament of Canada, which appropriation must constitute a lawful authority for making the said payment during the fiscal year in which the payment becomes due;

(2) **Accounting and Audit:** Each funding agreement to be entered into by the Federal Government and the FNHA or the FNHS pursuant to the Framework Agreement will, unless otherwise agreed in writing, require the FNHA and the FNHS, in respect of each such agreement, to:

(a) maintain financial records and prepare financial statements in accordance with generally accepted accounting standards in the province of BC;

(b) be audited on an annual basis by an independent auditor recognized by the province of BC; and

(c) make its accounting records and audit reports available to the Federal Government and to permit the Minister of Health and the Auditor General of Canada to conduct or cause to be conducted a financial or performance audit.

6.7 Schedule "A" (Details of Federal Funding)

Schedule "A" (Details of Federal Funding) contains certain 2008/9 BC budget information for FNIH programs for First Nations living in the province of BC. It is attached to this Basis Agreement for use with reference to subsections 6.1(3), (4) and (5) and for reference purposes only. In the event of a conflict or inconsistency between the Schedule and this Basis Agreement, the terms of this Basis Agreement will prevail.

7: ROLE OF THE PROVINCE AND THE PROVINCIAL HEALTH AUTHORITIES

The Agreement provides a unique opportunity for the development of a direct partnership between First Nations and Health Authorities, which will be dynamic and evolving. There will be a shared accountability to improve the health outcomes for BC First Nations.

It is also understood that health outcomes for First Nations people will only be improved if the First Nations Health Authority has the full support of the Province and Health Authorities, both as governance and service delivery partners. Therefore, the Province reaffirms its role as funder, governance and service delivery partner. New processes for full collaboration and decision-making are outlined in the sections below on Reciprocal Accountability and Reporting and Process.

The Province anticipates that as the FNHA evolves and First Nations communities work with it to create solutions to improve health services, these solutions will involve a variety of innovative arrangements with the Ministries and Health Authorities.

These new arrangements need to be planned and determined at the local and regional level between First Nations communities and the Health Authorities, with the support of the Province and the FNHA. Consistent with the Health Authorities Act, the Province therefore commits to working with the Health Authorities and the FNHA to ensure that innovative arrangements will be discussed and appropriate funding agreements established at a time mutually agreed upon. In particular, the Province and the FNHA intend that as soon as practicable, the Province would transfer the Provincial Aboriginal Physician Advisor position to the FNHA. The FNHA and the Province intend to work together to potentially evolve the position into a new role such as a First Nations Provincial Health Officer.

"Each health authority and the First Nations in their service delivery area will develop Aboriginal Health Plans that are consistent with the priorities in this Plan, and that emphasize actions on issues unique or specific to each region. In addition, each health authority will involve First Nations in collaborative decision-making regarding delivery of Health care services for Aboriginal people. This will allow for better coordination between First Nations community health plans and the Aboriginal health services plans of the health authorities." (page 6, TCA:FNHP)

7.1 PROVINCIAL FUNDING AND ACCOUNTABILITY

The Province has committed to the funding of the TFNHP, which includes the creation of the new FNHA. To that end, the Province committed $100 million to the implementation of the TFNHP. The Ministries of Healthy Living and Sport and Health Services have provided $16.5 million to the First Nations Health Council over the past three years and a payment schedule has been agreed to for the balance of $83.5 million over the next 10 years.

Accountability processes outlined in the funding letter of January 19, 2010, include:

- Review of health outcomes in First Nations communities at the Provincial Committee on First Nations Health, co-chaired by Deputy Ministers, Ministry of Healthy Living and Sport and Ministry of Health Services, with First Nations and the federal government, with participation by Health Authority Chief Executive Officers.

- Evaluation of progress and initiatives through a reciprocal accountability framework under development by the Tripartite partners,
- Tracking of progress using the seven performance indicators in the TFNHP: Life expectancy at birth; mortality rates (deaths due to all causes); youth suicide rates; infant mortality rates; childhood obesity; and practicing, certified First Nations health care professionals.)

Accounting and Audit: Each funding agreement that may be entered into by the Province and the FNHA pursuant to the Framework Agreement will, unless otherwise agreed in writing, require the FNHA, in respect of each such agreement, to:

(a) Maintain financial records and prepare financial statements in accordance with generally accepted accounting standards in the Province of BC;

(b) Be audited on an annual basis by an independent auditor recognized by the Province; and

(c) Make its accounting records and audit reports available to the Province and to permit the Ministers of Health Services and Healthy Living and Sport and the Auditor General of BC to conduct or cause to be conducted a financial or performance audit.

8: RECIPROCAL ACCOUNTABILITY AND REPORTING

The TFNHP committed the Parties to develop a governance plan based on reciprocal accountability. The Parties are committed to observing and upholding the principles of reciprocal accountability that include:

a) Clear Roles and Responsibilities - Roles and responsibilities should be well understood and agreed on by the Parties.
b) Clear performance expectations - The objectives, the expected accomplishments, and the constraints, such as resources, should be explicit, understood and agreed on.
c) Balanced Expectations and Capacities - Performance expectations should be linked to and balanced with each party's capacity to deliver.
d) Credible Reporting - Credible and timely information should be reported to demonstrate what has been achieved, whether the means used were appropriate, and what has been learned.
e) Reasonable Review and Adjustment - Fair and informed review and feedback on performance should be carried out by the Parties, achievements and difficulties recognized, appropriate corrective action taken and appropriate consequences carried out.

8.1 PROCESS

The Parties will develop a plan that shall provide for opportunities and obligations for the Parties to meet and review the progress in implementing the Framework Agreement, the TFNHP, the FNHP-MOU, and the TCA-FNIIP which shall include:

a. A Biennial Principals Meeting - in accordance with the principles and commitments set out in the TFNHP;
b. Regular Meetings of the Provincial Committee on First Nations Health;
c. Regular meetings between Health Canada and FNHA - to be held at least annually with a focus on national policies, priorities and plans and the implications for BC First Nations;
d. Regular Meetings between FNHA and FNIHB;
e. First Nations Caucus Sessions - will be held at least once each 18 months and will include all BC First Nations and their health organizations;
f. Regular Governance Partnership Meetings - will be held at least once each 18 months;
g. Subject-matter multi-party working groups will be established by the Parties to pursue issues in greater detail. These working groups will address issues related to implementation of the TFNHP, this Framework Agreement and/or the First Nations health governance structure and other issues of importance which may require referral to the Biennial Principals Meeting; and
h. Creation of direct linkages and opportunities for consultation between the FNHA and the Province and the Federal Government and their respective government departments, ministries and agencies on all matters relating to First Nations health and health programs.

9: PERFORMANCE TRACKING

The *First Nations Health Plan Memorandum of Understanding* and the *Transformative Change Accord: First Nations Health Plan* identify seven performance indicators (life expectancy at birth; mortality rates (deaths due to all causes); Status Indian youth suicide rates; infant mortality rates; diabetes rates; childhood obesity; practicing certified First Nations health care professionals). The FNHA will use these seven performance indicators and develop other indicators, as appropriate.

In recognizing this, and our joint commitment in the 2007 Tripartite First Nations Health Plan to tracking progress on closing the gap in health status between First Nations and other British Columbians, the Parties commit to identifying the additional key indicators in the areas of measuring new and improved health governance, management and service delivery relationships at all levels as well as additional wellness indicators.

The Parties will develop an initial set of indicators and will identify some targets and goals for the new First Nations health governance structure prior to the effective date of transfer of the BC FNIH operations to the new FNHA. The Parties will review, evolve, modify and develop indicators as needed.

10. CONCLUSION OF HEALTH GOVERNANCE AGREEMENT

Following the initialing of this Basis for a Framework Agreement on Health Governance document, the Parties agree to negotiate a Framework Agreement by October 2010 or as soon as practical thereafter.

The parties agree that the Framework Agreement will require significant change in policy, funding relationships, and the organization of and delivery of services. To guide and

ground the work required to achieve change, the Parties will further refine a shared vision for the First Nations Health Authority, its roles, responsibilities, and functions, and its relationship to both federal and provincial health programs, services and functions. The key elements of change strategy and transition required to achieve the shared vision will be addressed as part of the implementation plan.

11. IMPLEMENTATION AND TRANSITION

a) Implementation Plan

The Parties agree to establish a five (5) year implementation plan to begin upon signing of the Framework Agreement. The Implementation Plan will include detailed plans for the transfer of programs, services, authorities, and functions, the specific actions and obligations to be carried out by the Parties to implement the Framework Agreement, and any other matters as agreed upon by the Parties.

b) Legislation

The Province understands that the new FNHA may need to be recognized in provincial legislation, as well as in federal legislation to ensure clarity of jurisdiction and authority. The Province commits to exploring ways to recognize the FNHA's legal status including legislation.

The Federal Government commits to explore ways to acknowledge and express support for implementation of the Framework Agreement through federal legislation.

c) Unforeseen Circumstances

In the event of an unforeseen circumstances of a health emergency or natural disaster which would have a significant capacity or financial impact on the FNHA, the Federal Government, the Province and the FNHA, will jointly assess the impact and required measures to address the situation. Any agreement to provide new funding or other assistance to the FNHA will be made by the Parties in writing.

11.1 IMPLEMENTATION COMMITTEE

The Parties will, within three (3) months from the signing of the Framework Agreement, establish a committee to develop and oversee the performance of the Implementation Plan. The Implementation Committee may consist of one member appointed by the Federal Minister of Health, one member appointed by the Province, one member appointed by the First Nations Health Society and one member appointed by the First Nations Health Council, and that appropriate sub-committees may be established as deemed necessary by the Implementation Committee.

11.1.1 Roles and Responsibilities of the Implementation Committee

The role and responsibilities of the Implementation Committee shall include:

- Oversight and direction on the implementation of the Framework Agreement;

- Development of the Implementation Plan for the FNHA and monitoring the implementation of the Framework Agreement;
- Identifying timelines for the transfer of identified programs, services, authorities, and functions from HC to the FNHA;
- Establishment of the Transition Team to develop a transition plan to transition key functions from HC to the FNHA. The Transition Team will include a senior executive who is responsible for the development of the FNHA. This plan will cover a one to two year time frame;
- Identify timelines and implementation plans for the transfer of any agreed upon provincial programs, services, authorities and functions to the FNHA; and,
- Engage and communicate with First Nations and other stakeholders on implementation.

11.2 IMPLEMENTATION FUNDING

Implementation funding as described in Section 6.3 will be included in the provisions of the funding agreements to be entered into subsequent to the signing of the Framework Agreement.

11.3 INTERIM ARRANGEMENTS WITH HC/FNIH

11.3.1 FNIH BC Region Budget Levels

During the period of time from the effective date of the Framework Agreement until the date or dates for the transfer of programs, services, functions and activities to the FNHA, Health Canada will maintain the budget allocation to the BC Regional Office for the First Nations and Inuit Health program at a level no less than that of the allocation in the fiscal year of the effective date of the Framework Agreement.

11.3.2 Joint Management Arrangements

During the period of time from the effective date of the Framework Agreement and the date or dates for the transfer of PFSA from Health Canada to the FNHA there shall be established an Interim Joint Management Committee made up of the Regional Director FNIH and an individual designated by the First Nations Health Society. This Committee will review and discuss all significant and strategic level management, program or policy issues that would be decided on by the Regional Director (RD) FNIH. These discussions will happen prior to the RD making a decision. The Committee will attempt to reach agreement on the decision to be taken.

The Interim Joint Management Committee will meet as frequently as required but no less than two times per month.

The Interim Joint Management Committee will also establish a Senior Management team made up of the senior managers of the FNIH program and the new senior managers of the FNHC. This Senior Management Team will facilitate the learning of the FNHC managers re their respective roles and responsibilities in relation to operating FNIH Programs, services, functions and authorities as part of the new FNHA. Health Canada will also provide opportunities for the Senior Management team to meet with Health Canada Headquarters personnel in support of any additional learning. The Senior Management team will also

work closely with the Transition team and support the implementation of the transition plan.

The Interim Joint Management Committee would exist not more than 2 years, until the work to carry out the transition of the FNIH operations into the FNHA is complete.

12. APPROVAL

This "Basis for a Framework Agreement on Health Governance" will be initialled by the lead negotiators of each of the Parties. The Federal and Provincial negotiators will submit to their Principals with a recommendation that each party seek authority to conclude a Framework Agreement based on this document.

The First Nations negotiators will seek direction from the five First Nation health caucuses followed by the First Nations Health Council holding an Assembly of Chiefs to consider and endorse a resolution to conclude a Framework Agreement based on this document. The Basis Agreement is a continuation of the commitment set out in the TFNHP, which was also approved by resolutions.

Following the initialing of a Framework Agreement, BC First Nations will participate in a nation-based ratification process for the governance structure, functions, and relationships of a new First Nations health governance structure. This process will require a resolution of support ratifying the Framework Agreement at a First Nations Health Council Assembly.

The Parties acknowledge and agree that this Basis Agreement and for greater certainty any of its provisions are not legally binding on any of the Parties and are without prejudice to the respective legal positions of the Parties.

Schedule A

DETAILS OF FEDERAL FUNDING FOR BC FIRST NATIONS HEALTH FRAMEWORK AGREEMENT

Table 1: SUMMARY, BASE YEAR 2008-2009 AMOUNTS

PROGRAM/SERVICE	FUNDING
Regional Community Programs	$127,656,800
Tripartite First Nations Health Plan	$6,000,000
Regional Sun-setting Programs	$16,807,800
Non-Insured Health Benefits Program	$135,520,700
Capital	$10,340,800
Policy and Program Leadership (FNIHB HQ)	$7,819,300
Corporate and Management Services (includes EBP)	$12,839,900
Accommodations	$1,847,100
TOTAL BASE YEAR AMOUNT	**$318,832,400**
IMLEMENTATION FUNDING (one-time funding)	**$17,000,000**
ANNUAL ESCALATOR	
All programs transferred	5.5%
NIHB not transferred	4.5%
Tripartite Health Plan Top Up (in 2008-09 value) * Payment starting in transfer year to top up amount to $10,000,000	$4,000,000 *

Table 2 – Details of Federal Funding for Program Transfer, Fiscal Year 2008-09 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2008-09 ($,000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	133,656.8	0	0	133,656.8
Regional Supsetters	16,807.8	0	0	16,807.8
Non-Insured Health Benefits (NIHB)	0	135,520.7	0	135,520.7
FNIHB HQ Policy and Programs	5,158.0	2,661.3	0	7,819.3
Corporate and Management	7,705.6	596.1	0	8,301.7
Employee Benefit Plan	4,238.6	299.6	0	4,538.2
Capital	0	0	10,340.8	10,340.8
Accommodations	1,847.1	0	0	1,847.1
TOTAL	169,413.9	139,077.7	10,340.8	318,832.4

Table 3 – Fiscal Year 2010-11 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2010-11 ($000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs / Tripartite Health Plan	139,061.3	0	0	139,061.3
Regional Sunsetters	16,838.6	0	0	16,838.6
Non-Insured Health Benefits (NIHB)	0	151,264.3	0	151,264.3
FNIHB HQ Policy and Programs	5,246.9	2,681.5	0	7,928.4
Corporate and Management	7,843.0	608.5	0	8,451.5
Employee Benefit Plan	4,375.9	326.9	0	4,702.8
Capital	0	0	10,662.0	10,662.0
Accommodations	1,847.1	0	0	1,847.1
TOTAL	175,212.8	154,881.2	10,662.0	340,756.0

Table 4 – Fiscal Year 2011-12 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2011-12 ($000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	141,881.8	0	0	141,881.8
Regional Supsetters	16,854.4	0	0	16,854.4
Non-Insured Health Benefits (NIHB)	0	159,807.8	0	159,807.8
FNIHB HQ Policy and Programs	5,292.4	2,691.8	0	7,984.2
Corporate and Management	7,913.1	614.9	0	8,528.0
Employee Benefit Plan	4,446.1	341.1	0	4,787.2
Capital	0	0	10,829.8	10,829.8
Accommodations	1,847.1	0	0	1,847.1
TOTAL	178,234.9	163,455.6	10,829.8	352,520.3

Table 5 – Fiscal Year 2012-13 Amount

PROGRAM COMPONENTS	ADJUSTMENT FACTOR SUMMARY ELEMENTS FOR 2012-13 ($.000 thousands)			
	COMMUNITY	NIHB	CAPITAL	TOTAL
Regional Community Programs + Tripartite Health Plan	144,784.2	0	0	144,784.2
Regional Sunsetters	16,870.4	0	0	16,870.4
Non-Insured Health Benefits (NIHB)	0	168,832.5	0	168,832.5
FNIHB HQ Policy and Programs	5,338.5	2,702.3	0	8,040.8
Corporate and Management	8,020.8	621.4	0	8,642.2
Employee Benefit Plan	4,517.3	355.5	0	4,872.8
Capital	0	0	10,998.0	10,998.0
Accommodations	1,847.1	0	0	1,847.1
TOTAL	181,378.3	172,511.7	10,998.0	364,888.0

Transformative Change Accord

-between-

Government of British Columbia

-and-

Government of Canada

-and-

The Leadership Council
Representing the First Nations of British Columbia

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

At the First Ministers' Meeting on Aboriginal issues on November 24th/25th, 2005, First Ministers and Aboriginal Leaders committed to strengthening relationships on a government-to-government basis, and on focussing efforts to close the gap in the areas of education, health, housing and economic opportunities.

This accord respects the agreement reached on November 25th and sets out how the parties intend to implement it in British Columbia.

Two important documents preceded the First Ministers' Meeting:

- *First Nations - Federal Crown Political Accord* – on the Recognition and Implementation of First Nations Governments signed in May 2005
- *The New Relationship* – A vision document setting out an initial work plan to move toward reconciliation of Aboriginal and Crown Titles and Jurisdictions within British Columbia

The goals in each document continue to be pursued and the understandings reached in both serve as the foundation for this tripartite accord.

The purpose of this Accord is to bring together the Government of British Columbia, First Nations and the Government of Canada to achieve the goals of closing the social and economic gap between First Nations and other British Columbians over the next 10 years, of reconciling aboriginal rights and title with those of the Crown, and of establishing a new relationship based upon mutual respect and recognition.

The Accord acknowledges and respects established and evolving jurisdictional and fiduciary relationships and responsibilities, and will be implemented in a manner that seeks to remove impediments to progress by establishing effective working relationships.

The actions and processes set out herein are guided by the following principles.

- Recognition that aboriginal and treaty rights exist in British Columbia.
- Belief that negotiations are the chosen means for reconciling rights.
- Requirement that consultation and accommodation obligations are met and fulfilled.
- Ensure that First Nations engage in consultation and accommodation, and provide consent when required, freely and with full information.
- Acknowledgement and celebration of the diverse histories and traditions of First Nations.
- Understanding that a new relationship must be based on mutual respect and responsibility.
- Recognition that this agreement is intended to support social and economic well-being of First Nations.
- Recognition that accountability for results is critical.
- Respect for existing bilateral and tripartite agreements.

The parties to this Accord acknowledge the importance of First Nations' governance in supporting healthy communities. Actions set out in this Accord and in subsequent action plans will reflect this reality.

The parties understand that new resources will be required to close the gaps and federal and provincial investments on and off reserve will be made available pursuant to the decisions taken at the November 2005 First Ministers' Meeting. The parties also recognize the need to examine how existing resources are expended with the view that transformative change will require different funding approaches.

The Province of British Columbia, the Government of Canada and the First Nations of British Columbia agree to establish a 10 year plan to bridge the differences in socio-economic standards between First Nation citizens and other British Columbians. It is understood that a 10 ten year plan must by necessity evolve over time, and that concrete actions are required at its outset to build the relationships and momentum to achieve the desired outcome.

Accordingly, the parties to this Accord agree to undertake immediate actions in the following areas:

- To improve relationships by:
  - Supporting a tripartite negotiation forum to address issues having to do with the reconciliation of Aboriginal rights and title;
  - Engaging in the review and renewal of claims, treaty implementation and self-government policies;
  - Holding an annual meeting of political leaders intended to jointly discuss issues of mutual concern, report on progress and plan ongoing action; and,
  - Developing and implementing a communications plan to increase public awareness of the diversity and value of First Nations cultures, including support for the 2008 North American Indigenous Games

Possible Indicators include:
- Concluded Treaties and other agreements
- Increased awareness by the public of diversity and value of First Nation cultures

- To close the gap in education by:
  - Concluding a tripartite agreement on First Nation jurisdiction over K-12 education;
  - Supporting First Nation learners;
  - Focusing resources on early childhood learning and post-secondary training, including skills, training and apprenticeships; and,
  - Creating a high quality learning environment for First Nation students through curriculum development, teacher certification and the early detection of, and response to, learning disabilities.

Possible Indicators include:
- First Nations children exhibiting readiness for Kindergarten.
- Aboriginal students meeting expectations in reading, writing and numeracy (Foundation Skills Assessment).
- K-12 (or Dogwood equivalent) completion rates .
- Aboriginal students enrolled in post-secondary education (alternatively "highest level of education attained").
- Number of First Nation teachers.
- K – 12 curriculum modules.

- To close the gap in housing and infrastructure by:
  - Building on-reserve housing units.
  - Developing a partnering agreement to address off-reserve housing.
  - Exploring the devolution and development of Aboriginal off-reserve housing units to an aboriginal housing authority.
  - Supporting capacity development in the area of housing, including building maintenance and standards, and training and employment having to do with housing construction;
  - Undertaking measures to ensure the safety of water supply;
  - Improving other basic infrastructure such as wastewater systems, roads and fire protection;
  - Undertaking comprehensive community planning; and,
  - Providing broadband connectivity to First Nation communities.

Possible Indicators include:

- First Nation households in core housing.
- First Nations people trained in construction and maintenance of housing and related infrastructure.
- Number of Aboriginal subsidized housing units .
- Number of on-reserve and off-reserve housing units built.
- On-reserve boil water advisories.
- First Nation communities with broadband access.

- To close the gap in health by[1]:
  - Establishing mental health programs to address substance abuse and youth suicide;
  - Integrating the ActNow strategy with First Nations health programs to reduce incidence of preventable diseases like diabetes;
  - Establishing tripartite pilot programs in the Northern Health Authority and the Lytton Health Centre to improve acute care and community health services utilizing an integrated approach to health and community programs as directed by the needs of First Nations; and,
  - Increasing the number of trained First Nation health care professionals.

[1] BC First Nations will be supported in the health actions by the direction and contribution from the Assembly of First Nations.

Possible Indicators include:

- Increased life expectancy.
- Age standardized mortality rates.
- Youth suicides.
- Infant (up to one year) and neonatal (up to 28 days) mortality rates.
- Level of incidence of diabetes.
- Level of childhood obesity.
- Practising, certified First Nation health care professionals.

- To close the gap in economic opportunities by:
  - Providing increased access to lands and resources through interim measures;
  - Considering the implementation of revenue sharing arrangements;
  - Holding a provincial summit on economic development; and,
  - Supporting First Nations business and entrepreneurial development by increasing access to business training, and skills development and considering ways to facilitate greater access to capital funding sources.

Possible Indicators include:

- Employment rates.
- Average weekly and hourly wage levels (LFS data).
- Business start ups.
- Number of entrepreneurs in BC.
- First Nation registered apprentices.

The Parties agree that by December, 2006 a detailed tripartite implementation strategy will be developed laying out specific actions and building upon a shared commitment to undertake as many initiatives as possible in year one of the 10 year plan (2006 – 2016). The Parties understand the collective responsibility for reporting on the progress of closing the socio-economic gaps that exist between First Nations people and other British Columbians. Accordingly, resources will be focussed towards developing the data and information necessary to appropriately monitor and report on agreed upon action plans. Canada, British Columbia and the First Nations of British Columbia agree that regular public reports are necessary. Data collection will respect the privacy of individuals.

For greater certainty, nothing in this agreement shall be construed so as to abrogate or derogate from the protection of any existing or future Aboriginal or treaty rights of the First Nations peoples of British Columbia.

Signed this 25 day of November, 2005.

Canada

Rt. Honourable Paul Martin

Province of British Columbia

Honourable Gordon Campbell

First Nations Leadership Council

Representing the BC Assembly of First Nations:

A-in-chut

Regional Chief Shawn Atleo

Representing the First Nations Summit:

Grand Chief Edward John

Grand Chief Doug Kelly

Dave Porter

Representing the Union of BC Indian Chiefs:

Chief Stewart Phillip

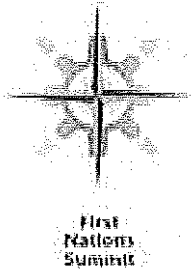
Chief Robert Shintah

Chief Mike Retasket

THE TRANSFORMATIVE CHANGE ACCORD: FIRST NATIONS HEALTH PLAN

SUPPORTING THE HEALTH AND WELLNESS OF FIRST NATIONS IN BRITISH COLUMBIA


British Columbia
Assembly of
First Nations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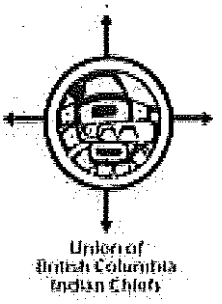
Union of
British Columbia
Indian Chiefs


BRITISH
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THE TRANSFORMATIVE CHANGE ACCORD: FIRST NATIONS HEALTH PLAN

SUPPORTING THE HEALTH AND WELLNESS OF FIRST NATIONS IN BRITISH COLUMBIA

TABLE OF CONTENTS

INTRODUCTION

In March 2005, the Province of British Columbia and First Nations leaders agreed to enter into a New Relationship guided by principles of trust, recognition and respect for Aboriginal rights and title. The New Relationship focuses on closing the gaps in quality of life between First Nations and other British Columbians.

Our Vision: Improve the health and well being of First Nations to close the health gap between First Nations and other British Columbians

In November 2005, the Province of British Columbia, the First Nations Leadership Council, and the Government of Canada signed a historic agreement entitled the Transformative Change Accord. The Accord recognizes the need to strengthen relationships on a government-to-government basis, and affirms the parties' commitment to achieve three goals:

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

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

The First Nations Leadership Council and British Columbia have developed this First Nations Health Plan to identify priorities for action to close the health gap between First Nations and other British Columbians. It is intended to guide our efforts to address the critical challenges that must be overcome in order to deliver on the joint commitments to improve the health and well-being of First Nations peoples and communities. It is our hope and expectation that the Government of Canada will join us in developing a tripartite implementation strategy for the health component of the Transformative Change Accord.

THE CHALLENGE

The difference in health outcomes between First Nations and other British Columbians is unacceptable and unsustainable.

In July, 2005 the *First Nations Health Blueprint for British Columbia*, developed by the First Nations Leadership Council, identified a new vision for First Nations health systems, and identified a number of gaps and barriers in health services in the areas of: delivery and access; sharing in improvements to Canadian health care; promoting health and well-being; monitoring progress; clarifying roles and responsibilities between governments and organizations; and developing ongoing collaborative working relationships. It identified a significant lack of access to existing services for First Nations people in rural areas, limited access to health care for First Nations women – particularly those living in rural communities, a debilitating crisis 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.

In 2001, the British Columbia Provincial Health Officer issued a landmark report on the health and well-being of Aboriginal people which highlighted significant gaps in health outcomes. He concluded that the risks of developing diabetes, pneumonia, or HIV/AIDS or experiencing injuries caused by motor vehicle accidents are greater for Aboriginal people than for other British Columbians. The British Columbia Coroners Service Child Death Review Report (2005) highlighted the disproportionately higher number of deaths of Aboriginal children in British Columbia. Approximately 20 per cent of reviewed deaths were of Aboriginal children, although Aboriginal children comprise less than 10 per cent of the population of British Columbia.

This First Nations Health Plan builds on and supports the *First Nations Health Blueprint for British Columbia*. It also considers the recommendations of the 2001 report of the Provincial Health Officer entitled *The Health and Well-being of Aboriginal People in British Columbia*, which was endorsed by First Nations. It recognizes that First Nations must be full partners in the design and delivery of health initiatives to benefit them and their communities to ensure their success in closing the health gaps. Reciprocal accountability between governments and First Nations is fundamental to addressing socio-economic disparities, and critical to improved government-to-government relationships.

Health for First Nations encompasses the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family and community. Closing the health gap must also include addressing conditions such as poverty, education, housing, employment and economic opportunities affecting First Nations.

While the actions in this Plan focus specifically on health related initiatives, actions to address the other priority areas of the Transformative Change Accord are underway or under development and will be complementary to, and coordinated with, the actions set out in this Plan. The Plan is intended to be a living document - one that is responsive to feedback from First Nations peoples and communities, health care professionals and practitioners, and others. Changes in health outcomes of First Nations will be regularly examined, and modifications to the action plan made to ensure continuous improvement in outcomes.

The federal government is a partner in the delivery of health care services and programs to First Nations people and communities. Their input and involvement is fundamental to the success of this Plan. It is our hope that over the next six months the federal government will work with us to augment this Plan to develop a tripartite implementation strategy for the health component of the Transformative Change Accord. The development of a tripartite strategy will also be informed by a province-wide Forum on First Nations Health in the spring of 2007.

JURISDICTIONAL CONTEXT

First Nations people receive health services through a unique combination of federal, provincial, and First Nations-run programs and services.

» ***Status First Nations live 7 years less than other British Columbians.***[1]

» ***Status First Nations have a diabetes rate 40% higher than the general population.***[2]

» ***49% of Aboriginal young people smoke, more than double the rate of other young people in B.C.***[3]

» ***The number one reason for day surgeries for children in B.C. is for dental treatment. First Nations Children are four times more likely to require such treatment than non-First Nations children.***[4]

1 Provincial Health Officer 2001 annual report

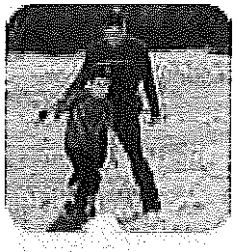
2 Provincial Health Officer 2001 annual report

3 Provincial Health Officer 2004 annual report

4 First Nations Summit Regional Longitudinal Health Survey 2002/03

The Province has responsibility for providing all aspects of health services to all residents of British Columbia, including Status Indians living on and off-reserve. The federal government has a financial responsibility to support the delivery of health services to Status Indians on reserve and pays for Medical Services Plan premiums for Status Indians.

The federal government, through the First Nations and Inuit Health (FNIH) department of Health Canada, also provides for a range of health programs (specifically non-Insured Health Benefits, limited treatment services, health promotion, and injury and disease prevention) for First Nations people on reserve. In partnership with FNIH, many First Nations communities have established their own community health facilities (164 in British Columbia) and deliver a wide range of health programs and services. Funding for these programs and services are provided to First Nations communities through a variety of agreements which vary in terms of level of control, flexibility, and accountability. Through these mechanisms, a wide network of First Nations health centres, professionals and practitioners has been established to provide a community-based approach to providing health services to British Columbia's First Nations. It is this network and these community-based solutions that must be developed and supported.



This multi-jurisdictional health care system for First Nations at times creates gaps, discontinuities and inadequacies in service. Programs to address health problems are often developed independently by one or more of the provincial, federal or First Nations partners, so that well intentioned initiatives may create overlaps or duplication. Further, health data are not readily available for non-status, Métis or Inuit, so that the broad picture of Aboriginal health in British Columbia must be extrapolated from Status Indian data[5]. In some cases, data-sharing to ensure that all parties can track health outcomes and identify emerging issues or successes is lacking.

THE TRANSFORMATIVE CHANGE ACCORD - HEALTH

The Transformative Change Accord identifies four areas of action to help close health gaps over the next ten years:

1. Establish mental health programs to address substance abuse and youth suicide;
2. Integrate ActNow BC strategy with First Nations health programs to reduce incidences of preventable diseases like diabetes;
3. Establish tripartite pilot programs in the Northern Health Authority and build the Lytton Health Centre to improve acute care and community health services utilizing an integrated approach to health and community programs as directed by the needs of First Nations; and,
4. Increase the number of trained First Nations health care professionals.

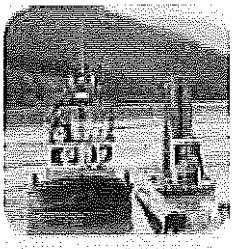
The actions identified in the Transformative Change Accord are necessary but not sufficient to close the health gaps. Therefore, the actions in this Plan build on the actions in the Accord, and include actions set out in the First Nations Health Blueprint for British Columbia and the 2001 Provincial Health Officer's report.

5 It is estimated that there are 30,000 non-status Indians and 44,000 Métis in British Columbia.

THE WAY FORWARD

First Nations and the Province have identified actions required in four key areas:

- Governance, relationships and accountability;
- Health promotion and disease and injury prevention;
- Health services; and,
- Performance tracking.



GOVERNANCE, RELATIONSHIPS AND ACCOUNTABILITY

There are a variety of efforts underway – being carried out by First Nations, health authorities and other health organizations – to address the health needs of First Nations people and to support increased First Nations control, ownership and responsibility relating to their health status. For example, Aboriginal communities and organizations provide some input into health planning and service delivery through regional and local Aboriginal advisory bodies that have been created in each of the health authorities. First Nations communities have established their own health centres and deliver a wide range of health services in their communities. 175 of 203 First Nations communities in British Columbia have developed community health plans, which are updated on an annual basis.

Notwithstanding this progress, a variety of factors continue to contribute to poor health outcomes for First Nations. First Nations continue to have inadequate involvement in the planning and delivery of provincial or federally funded health care services. Provincial, federal and/or First Nations health policies and programs are not well coordinated, and gaps exist in health care services between federal and provincial government systems.

There is an opportunity to improve the linkages between health planning at the community level and the regional planning activities of the health authorities. First Nations must be more involved in decision-making regarding their health and well-being, and must be involved in health planning, the delivery of health services and the monitoring of health outcomes. First Nations recognize their responsibility and leadership role to improve the health of First Nations individuals, families and communities. In order to support these things, First Nations require improved coordination, processes and mechanisms, and health care services must be provided in a collaborative and coordinated manner so that gaps in health care services can be closed and reciprocal accountability is implemented.

Action Plan

- First Nations will establish a new First Nations Health Council. This Council will report to the First Nations Leadership Council, and will be composed of the First Nations Chiefs' Health Committee, the Union of BC Indian Chiefs' Social Development Committee and others. The Council will serve three primary roles:
  1. To support all First Nations in achieving their 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 this Plan.

- The Provincial Health Officer will appoint an Aboriginal physician to advise on Aboriginal health issues and have specific responsibility for monitoring and reporting on the health of Aboriginal people in British Columbia and tracking progress against performance measures in this Plan.
- Each health authority and the First Nations in their service delivery area will develop Aboriginal Health Plans that are consistent with the priorities in this Plan, and that emphasize actions on issues unique or specific to each region. In addition, each health authority will involve First Nations in collaborative decision-making regarding delivery of Health care services for Aboriginal people. This will allow for better coordination between First Nations community health plans and the Aboriginal health services plans of the health authorities.
- A First Nations Health Advisory Committee will be established, whose membership will include: the CEOs of the five regional health authorities and the Provincial Health Services Authority, representatives of the First Nations Health Council, the Provincial Health Officer, the Aboriginal physician in the Provincial Health Officer's office and the Deputy Minister of Health. The Regional Director General for Health Canada will also be invited to participate. The First Nations Health Advisory Committee will:
  1. Review and monitor the Aboriginal health plans of British Columbia's health authorities;
  2. Take an active role in monitoring health outcomes in First Nations communities; and,
  3. Recommend actions that the province, First Nations or Health Canada should undertake to close health gaps.
- Establish a province-wide Health Partners Group, composed of the First Nations Health Council, federal and provincial governments, colleges and universities, health practitioner/professional groups and others, to share information on, and create recommendations for, closing the gap in health.
- First Nations and the Province will work toward developing a reciprocal accountability framework with the federal government to address gaps in health services for First Nations in British Columbia. The framework should clarify responsibility for health service delivery, and result in a more seamless and responsive health care system. The Education Jurisdiction Agreements should be explored as a potential governance model for First Nations health in British Columbia.

What will be different by 2015?

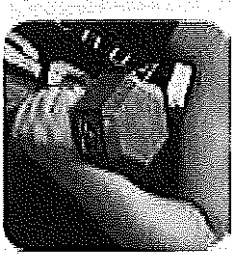
- First Nations will have greater input to, and be involved in decision-making for, health planning and service delivery for First Nations.
- There will be reciprocal accountability for health matters between First Nations and governments.
- First Nations leaders will have clear mechanisms for working with governments and health authorities, so that health services are better aligned with the needs of First Nations.
- First Nations will take a leadership role in improving the health of their communities and monitoring health outcomes.
- Gaps in health services will have been identified and addressed to the fullest extent possible.

HEALTH PROMOTION AND DISEASE AND INJURY PREVENTION

Early child development, education/knowledge and intervention, are important for health promotion and injury and disease prevention. First Nations communities currently deliver a range of programs to encourage healthy eating, exercising more, avoiding alcohol and drugs, and ensuring personal safety.

There are also a wide range of programs for mental health, family violence matters and youth suicide, among others. Eighty First Nations and Aboriginal organizations are creating local programs aimed at preventing, reducing and responding to crystal meth use in their communities, and are recruiting and training First Nations' outreach workers.

Health authorities currently deliver a range of services and programs related to health promotion and disease and injury prevention. For example, provincially-funded initiatives address chronic diseases such as diabetes, kidney disease and HIV/AIDS. In both the Interior and Northern Health Authorities there are programs to address family violence and motor vehicle accidents in First Nations communities. An Aboriginal Tobacco Reduction Strategy (*Honouring Our Health*) provides a model of a successful approach to community-led, community-based health promotion.



Notwithstanding these programs, more needs to be done. First Nations in British Columbia are a marginalized population – traditional lifestyles have been altered dramatically, leading to more sedentary lifestyles and reduced access to traditional foods and medicines. This has led to a disproportionately high incidence of preventable diseases among First Nations. For example, First Nations in British Columbia have a diabetes rate 40 percent higher than the rate of the general population.

First Nations are also dealing with the legacy of residential schools; the First Nations population has higher levels of substance abuse problems, and some communities have high rates of youth suicide. Injuries are also higher in the First Nations population; for example, motor vehicle crashes are one of the leading causes of injury and death for Aboriginal people – particularly for males between the ages of 15 and 24. Injuries are a particular problem in rural and remote communities with no primary care facility or hospital. A lack of healthy housing and lower educational achievement rates contribute to these challenges.

First Nations want to take action to improve their personal and community health. Appropriate programs must be in place to assist First Nations to deal with the most pressing health promotion and disease and injury prevention issues affecting their communities, so that the incidence of preventable diseases and injuries in the First Nations population becomes comparable to that of other British Columbians.

Action Plan

» The Minister of State for ActNow BC will work with First Nations communities and the First Nations Health Council, the National Collaborating Centre on Aboriginal Health[6], and health authorities to lead the development of a First Nations / Aboriginal specific ActNow BC program. Actions will include providing additional training to increase the number of First Nations community based workers trained in chronic disease prevention from 140 to 300 over 3 years, and the development of an Aboriginal ActNow BC strategy focused on better nutrition and increased physical activity, particularly among First Nations children.

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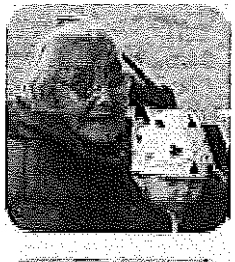
6 The National Collaborating Centre on Aboriginal Health located at the University of Northern British Columbia is one of six centres established by the Public Health Agency of Canada. The Centres are intended to work closely with the provinces on a series of select areas to develop, support and disseminate research and best practices. The centre in British Columbia is focused on Aboriginal health.



- Adult mental health, substance abuse, as well as young adult suicide will be addressed through an Aboriginal Mental Health and Addictions Plan that includes community-based programs such as healing circles, cultural camps and counselling programs that build community capacity. Suicide prevention efforts will be targeted, but not limited, to communities where suicide rates and/or attempts are high[7].

  The Province will work to ensure that services will be delivered seamlessly in conjunction with the Child and Youth Mental Health services delivered by the Ministry of Children and Family Development. New culturally relevant services will be implemented for Aboriginal children and families based on regional plans developed in consultation with regional Aboriginal planning committees to improve access to a range of core services. which include community-based assessment, counselling and therapy services, home-based and outreach services, as well as crisis intervention.

- The First Nations Leadership Council and the province will host a forum for all health authorities (Aboriginal Health Leads and Executive members) and First Nations Elders and youth to support and encourage learning about First Nations' heritage, cultures and spirituality, and to develop models for youth suicide prevention.
- Aboriginal children under age six (on and off-reserve) will receive hearing, dental and vision screening.
- First Nations and the province will follow-up on the British Columbia Coroners Service Child Death Review Report (2005) recommendation that "all levels of government, educators, parents, and Aboriginal leaders and their communities forge new relationships led by the Aboriginal people to address the results of this report that clearly illustrate that Aboriginal children are dying at disproportionately higher rates."
- First Nations and the province will work with the federal government to have prevention and primary health services on-reserve (including mental health and harm reduction) improved so that they meet or exceed those services provided to off-reserve populations by the health authorities.
- First Nations and the Province will continue to work with the federal government and others to improve First Responder programs in rural and remote First Nations communities.
- First Nations and the Province will continue to work with the RCMP, police detachments, Aboriginal organizations, ICBC and others to develop an information campaign to increase awareness about seatbelt use and safe driving.
- First Nations and the province will work to develop new culturally appropriate addictions beds/units for Aboriginal people.

What will be different by 2015?

- First Nations communities will deliver improved health promotion, and disease and injury prevention services to address key preventable diseases.
- All First Nations children will regularly receive vision, hearing and dental checks and treatment.
- First Nations people will experience lower levels of preventable diseases and injuries and can expect to live longer and healthier lives.

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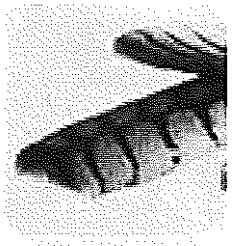
7 Process should be informed by Child and Youth Officer for British Columbia Special Report *Sayt K'uulm Goot – Of one Heart: Preventing Aboriginal Youth Suicide through Youth and Community Engagement.*

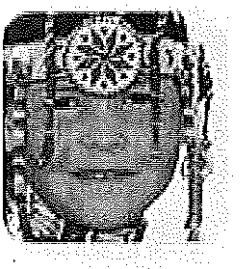
HEALTH SERVICES

Although most First Nations in British Columbia do not directly deliver primary health services, a small number of communities have nursing stations, open 24 hours a day, to provide treatment to community members. At a number of First Nations health care facilities, service delivery capacity is being increased in areas such as nursing, palliative care, and dental care. First Nations aim to continue increasing their capacity to directly deliver health services to their people and communities.

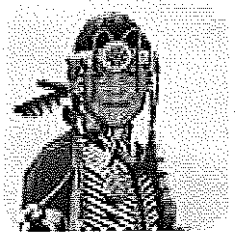
The majority of First Nations in British Columbia receive health services as other British Columbians do – through the provincial network of clinics, hospitals and other treatment facilities. Although some progress has been made in building relationships between First Nations and the provincial health system (mainly with health authorities), effective, collaborative working partnerships are not the norm.



Since 2001, the Province has invested over $50M in targeted funding for programs and services to improve Aboriginal health. Each health authority has also designated an Aboriginal Health Lead at a senior management level. The Aboriginal Health Leads are the primary contact for First Nations communities and are responsible for developing Aboriginal health plans that are tailored to address the needs of the Aboriginal population within each health authority, and overseeing targeted Aboriginal health initiative funding. The Province currently works with post-secondary institutions to encourage and support Aboriginal learners in the health disciplines. Universities and colleges take a number of approaches including: dedicated seats in health sciences programs, academic support, and laddering programs.



The University of British Columbia provides 13 dedicated seats for First Nations medical students, and works with health authorities to ensure relevant community residency experience. UBC, the University of Victoria, and the University of Northern British Columbia offer introductory workshops for Aboriginal students entering medicine.

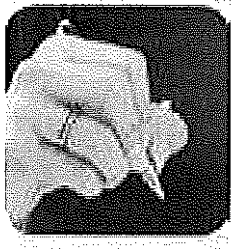


The Aboriginal Nursing Strategy has been developed with the aim of increasing recruitment and retention of Aboriginal nurses practising in B.C. and to increase the number of aboriginal communities in B.C. with quality nursing services.

Notwithstanding these activities, health services are not always available, accessible or culturally appropriate. Ongoing federal/provincial jurisdictional and funding issues have created gaps in health services. These issues need to be addressed so that First Nations are directly involved in decision-making and have equitable access to quality, culturally appropriate health services.

Action Plan

- The Province will build a health centre in Lytton. Proposed services may include an urgent care room, procedure room, laboratory, diagnostic imaging, physicians' clinic, future pharmacy, staff quarters and a six bed assisted living component.
- A Northern Health Authority pilot will be implemented in collaboration with Health Canada and First Nations service providers to develop an integrated approach to Chronic Disease Prevention and Management focused on diabetes in certain communities, using an Aboriginal Health Collaborative process. This will build on the successes of the Chronic Disease Prevention and Management Community Collaboratives implemented in the North during the last three years, with significant gains in access to services and improved patient outcomes.



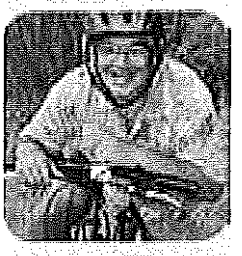
- The Province will dedicate post-secondary seats to Aboriginal health professions in order to increase the number of trained Aboriginal health care professionals. This will be coupled with work with public post-secondary institutions and Aboriginal communities in order to improve access, participation and success of Aboriginal learners in post-secondary health care programs.
- First Nations and the province will develop a curriculum for cultural competency in 2007/08, and require health authorities to begin this training in 2008/09. Training will be mandatory for Ministry of Health and health authority staff, including executive and senior management.
- A senior person will be assigned responsibility for Aboriginal health in each of the 16 Health Service Delivery Areas. These staff will report to the Aboriginal Health Lead in each health authority, and will work with local program and services staff on behalf of First Nations to better meet the non-hospital health service needs of Aboriginal people. They will also assist in the development of the Aboriginal health services plans in consultation with First Nations in their geographic area.
- A Maternity Access Project will be implemented to improve maternal health services for Aboriginal women and bring birth "closer to home and back into the hands of women." This will help reduce the need for First Nations women in rural and remote communities to travel to more urban centres up to two months prior to delivery because of a lack of maternity care in their home communities. The project will have several components including diversity training for care providers, training of birth companions and Aboriginal midwives, and the creation of a community guide and toolkit. The investment in this program will in the long-term be offset by a decrease in costs associated with medical evacuations and transfers, and a reduction in emergency care costs.
- Support will be provided to First Nations living with chronic health conditions such as diabetes, HIV/AIDS and Hepatitis C by introducing integrated primary health services programs and patient self-management programs.
- First Nations and the province want to create a fully integrated clinical telehealth network. This network could extend access and link First Nations communities with health centres on reserve to a comprehensive telehealth network. It could also be integrated with the systems of health authorities, to allow First Nations to participate in the training and professional development programs offered by health authorities. First Nations and the provincial government will work to explore funding options for this project with the federal government for capital start-up and ongoing operational costs for First Nations communities including network, video conference equipment and related medical devices, technology support staff, and other related costs.
- Access to primary health care services in Aboriginal health and healing centres will be improved by further developing the role of the Nurse Practitioner and enhancing physician participation in these centres through a number of contractual options and incentives.
- Each regional health authority will increase the number of professional and skilled trades First Nations in health professions. Health authorities will identify emerging employment opportunities in health authorities, share that information, and then link Aboriginal learners with appropriate training institutions.
- The number of Aboriginal Hospital Liaison staff employed by health authorities will be increased. There are currently 12 of these staff in health authorities. The aboriginal hospital liaison staff assist patients and families to navigate the health system and also provide links to community-based services. They also ensure appropriate discharge plans are in place, and that facility staff work collaboratively with community health workers. To the extent possible, First Nations staff will be recruited into these positions.

What will be different by 2015?

- Health services will be more culturally sensitive, better tailored to the specific needs of First Nations communities and more often delivered by First Nations health professionals.
- For those First Nations that are in rural and remote settings, telehealth systems and liaison staff will help ensure they receive care in rural and remote settings.
- First Nations women will have more options to deliver their children in their communities.

PERFORMANCE TRACKING

In 2001 the Provincial Health Officer produced a report on the health and wellness of Aboriginal people in British Columbia. This report provided vital data and analysis on which to assess the gap in health outcomes between First Nations and other British Columbians.



A tripartite agreement between the Government of British Columbia, Health Canada's First Nations and Inuit Health Branch and the First Nations Chiefs' Health Committee, facilitates data linkages and defines how federally and provincially held information on First Nations is to be used and shared.

The Michael Smith Foundation for Health Research (MSFHR), funded by the Province, has established an Aboriginal health research network - the Network for Aboriginal Research BC (NEARBC) located at the University of Victoria. NEARBC's goal is to improve the health and well-being of Aboriginal people in B.C. by developing collaborative research capacity that is relevant to Aboriginal people and is competitive for funding.

While progress has been made, more needs to be done. Currently, data collection and sharing between the federal and provincial governments and First Nations is often restricted, not timely and inadequate. Regular monitoring of health outcomes is required to ensure that programs and services are meeting the health needs of First Nations, while respecting the privacy of individuals.

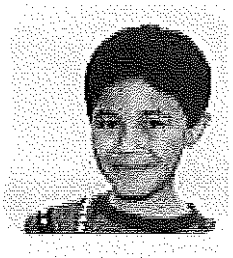
Health status and health care information related to First Nations health needs to be accurate, reliable, accessible, and contribute to measuring and closing the gap. Resources need to be focused towards developing the data and information necessary to appropriately monitor and report on agreed-upon action plans.

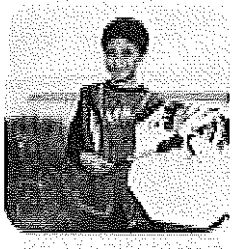
Action Plan

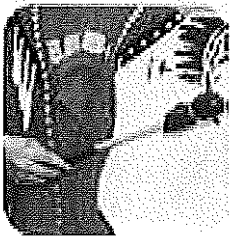
- The Provincial Health Officer will issue Aboriginal health status reports every five years, with interim updates every two years.
- The First Nations Chiefs' Health Committee and the Province want to renew the tripartite agreement between the Government of British Columbia, Health Canada's First Nations and Inuit Health Branch and First Nations to ensure federally and provincially held information on First Nations is shared. These data will facilitate research and reports on the health of First Nations people living in British Columbia.
- The Provincial Health Services Authority in collaboration with the First Nations Leadership Council and the Ministry of Health will expand its community health survey to include First Nations. The survey will collect valuable data on risk factors such as obesity; physical activity and nutrition. These data will provide First Nations communities and health care providers with valuable information for planning health services and monitoring changes in health status.

What will be different by 2015?

- British Columbia and First Nations will have health status and health care information for all Aboriginal people. This will facilitate research, new programs, plans and performance tracking.
- The Provincial Health Officer's regular reports on the health status of the Aboriginal population will measure the effectiveness of programs in closing the gap in health between First Nations and other British Columbians.
- Governments and First Nations will have clear mechanisms for sharing data on the health of First Nations in B.C.







MEASURING PROGRESS

First Nations and the province will be held jointly accountable for the outcomes of this First Nations Health Plan. Progress will be tracked using the following performance indicators proposed in the Transformative Change Accord:

- Life expectancy at birth;
- Mortality rates (deaths due to all causes);
- Status Indian youth suicide rates;
- Infant mortality rates;
- Diabetes rates;
- Childhood obesity; and,
- Practising, certified First Nations health care professionals.

First Nations and the Province will also consider other performance indicators which may assist in tracking progress on closing the gap in health outcomes.

Life Expectancy

Life expectancy at birth is a prediction of the average number of years a newborn person can be expected to live. Life expectancy for Status Indians is improving, but not at the same rate as other residents. Currently, Status Indians born between 2001 and 2005 can expect to live nearly 75 years, while other residents can expect to live 82 years.

- Our target is to decrease the gap in ***life expectancy*** between Status Indians and other British Columbians by 35% to less than 3 years difference by 2015.

Mortality Rate

An age standardized mortality rate (ASMR) measures the number of deaths due to all causes, expressed as a rate per 10,000 people. The measure allows for comparisons in death rates between two or more populations by adjusting for differences in population age distribution (i.e. the Status Indian population has a younger average age than other British Columbians). Currently, the age standardized mortality rate for Status Indians is 1.5 times greater than for other British Columbians.

- Our target is to reduce the gap in ***mortality rates*** between Status Indians and other British Columbians by 35% by 2015.

Youth Suicide

Youth suicide rates measure deaths among 15 to 24 year-olds who deliberately take their own lives. The measure is expressed as a rate per 10,000 people. The rate of youth suicide for Status Indians is about five times that of other youth.

Youth suicide is not an issue in every First Nations community. Between 1983 and 2000, more than half of First Nations communities in British Columbia reported no youth suicide.

» Our target is to reduce the gap in ***youth suicide rates*** between First Nations and other British Columbians by 50% by 2015.

It is also our objective to increase the number of First Nations communities with no youth suicide over time.

Infant Mortality Rate

The infant mortality rate measures the number of infants who die in the first year of life, expressed as a rate per 1,000 live births. About eight of every 1,000 Status Indian infants die in their first year, compared with a rate of about four infant deaths among other British Columbians. There is an average of 27 Status Indian infant deaths each year.

» Our target is to reduce the gap in ***infant mortality*** between First Nations and other British Columbians by 50% by 2015.

Diabetes

Diabetes is a chronic condition that results from a deficiency or ineffective use of insulin in the body. The Provincial Health Officer reports the prevalence rate of diabetes among Status Indians is 6.0%, as compared to 4.5% in other British Columbians, with approximately 5,600 Status Indians having already been diagnosed with diabetes.

Increased testing proposed in this Plan will capture existing unreported cases of diabetes. Establishing a stable baseline will help inform how and where to better focus prevention and management initiatives.

» Our target is to reduce the gap in the ***prevalence of diabetes*** between First Nations and other British Columbians by 33% by 2015.

Childhood Obesity

There are no routinely collected measures of childhood obesity for First Nations in B.C. A baseline and an ongoing mechanism for collecting relevant data will be developed.

Practising, Certified First Nations Health Care Professionals

There is no accurate information on the number of certified health care professionals in British Columbia who are First Nations, nor is there accurate information on how many of these are actually practising. A baseline and an ongoing mechanism for collecting relevant data will be developed.

CONCLUSION

The gap in health outcomes between First Nations and other British Columbians is unacceptable and unsustainable. First Nations' health outcomes must be improved. Through the New Relationship and the Transformative Change Accord, the First Nations Leadership Council and the Province committed to closing the gap in health outcomes for First Nations.

This Plan, built upon the *First Nations Health Blueprint for British Columbia*, identifies a new vision for First Nations' health – a vision that the First Nations Leadership Council and the Province are committed to implementing.

The First Nations Leadership Council and the Province are also committed to using this Plan as a framework for working with the federal government to develop a tripartite Transformative Change Accord Implementation Strategy for health that will mobilize the resources of the parties to close the gap in health outcomes and improve health services to First Nations in British Columbia.

APPENDIX: ACTION PLAN SUMMARY

Governance, Relationships and Accountability

1. Establish a new First Nations Health Council.
2. The Provincial Health Officer will appoint an Aboriginal physician to advise on Aboriginal health issues.
3. Each health authority and the First Nations in their service delivery area will develop Aboriginal Health Plans that are consistent with the priorities in this Plan, and that emphasize actions on issues unique or specific to each region.
4. Establish a First Nations Health Advisory Committee.
5. Establish a province-wide Health Partners Group.
6. Develop a reciprocal accountability framework to address gaps in health services for First Nations in B.C.

Health Promotion / Injury and Disease Prevention

7. The Minister of State for ActNow BC will work with First Nations communities and the First Nations Health Council, the National Collaborating Centre on Aboriginal Health, and health authorities to lead the development of a First Nations / Aboriginal specific ActNow BC program.
8. Adult mental health, substance abuse as well as young adult suicide will be addressed through an Aboriginal Mental Health and Addictions Plan.
9. The First Nations Leadership Council and the Province will host a forum for all health authorities (Aboriginal Health Leads and Executive members) and First Nations Elders and youth to support and encourage learning about First Nations' heritage, cultures and spirituality, and to develop models for youth suicide prevention.
10. Aboriginal children under age six (on and off-reserve) will receive hearing, dental and vision screening.
11. First Nations and the province will follow-up on the British Columbia Coroners Service Child Death Review Report (2005) recommendation that "all levels of government, educators, parents, and Aboriginal leaders and their communities forge new relationships led by the Aboriginal people to address the results of this report that clearly illustrate that Aboriginal children are dying at disproportionately higher rates."
12. First Nations and the province will work with the federal government to have prevention and primary health services on-reserve improved so that they meet or exceed those services provided off-reserve.

13. Improve First Responder programs in rural and remote First Nations communities.
14. Develop an informational campaign to increase awareness about seatbelt use and safe driving.
15. Develop new culturally appropriate addictions beds/units for Aboriginal people.

Health Services

16. Build a health centre in Lytton.
17. A Northern Health Authority pilot will be implemented to develop an integrated approach to Chronic Disease Prevention and Management.
18. Dedicate post-secondary seats to Aboriginal health professions.
19. First Nations and the Province will develop a curriculum for cultural competency in 2007/08 for health authorities.
20. A senior individual will be designated responsibility for Aboriginal health in each of the 16 Health Service Delivery Areas.
21. A Maternity Access Project will be implemented to improve maternal health services for Aboriginal women and bring birth "closer to home and back into the hands of women."
22. Introduce integrated primary health services programs and patient self-management programs to support First Nations living with chronic health conditions.
23. Create a fully integrated clinical telehealth network.
24. Further develop the role of the Nurse Practitioner and enhance physician participation in Aboriginal health and healing centres.
25. Increase the number of professional and skilled trades First Nations in health professions.
26. Increase the number of Aboriginal Hospital Liaison staff employed by health authorities.

Performance Tracking

27. The Provincial Health Officer will issue Aboriginal health status reports every five years, with interim updates every two years.
28. Renew the tripartite agreement between the Province, Health Canada's First Nations and Inuit Health Branch and First Nations to ensure federally and provincially held information on First Nations is shared.
29. Expand the community health survey to include First Nations.

Tripartite First Nations Health Plan

Between

The First Nations Leadership Council
Representing the BC Assembly of First Nations, the First Nations Summit
and the Union of BC Indian Chiefs

And

Government of Canada

And

Government of British Columbia

(Collectively the "Parties")

Canada

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Introduction

On November 27, 2006, the British Columbia First Nations Leadership Council (FNLC) and the Province of British Columbia negotiated the ten-year *Transformative Change Accord: First Nations Health Plan* (TCA:FNHP), (attached as Appendix "A"), which identifies twenty-nine actions intended to close the gaps in health status between First Nations people and other British Columbians. The TCA: FNHP was inspired by the *First Nations Health Blueprint for British Columbia*, published by the FNLC in July 2005, and the 2001 Report of the Provincial Medical Health Officer, *The Health and Well-being of Aboriginal People in British Columbia.*

Also, on November 27, 2006, the FNLC, the Government of Canada, and the Province of British Columbia signed a *First Nations Health Plan Memorandum of Understanding* (attached as Appendix "B"). This MOU commits the Parties to the development of a tripartite First Nations Health Plan by May 27, 2007, using the *Transformative Change Accord: First Nations Health Plan* as a framework.

Purpose

To build on the *First Nations Health Plan Memorandum of Understanding* and the TCA:FNHP through the development of a 10 year Tripartite First Nations Health Plan ("Plan") that:

a) Creates fundamental change for the improvement of the health status of First Nations people in British Columbia;

b) Defines a series of founding principles that will underpin the development and implementation of a new governance system for health services and guide systemic changes; and,

c) Establishes goals for the successful implementation of short and medium-term actions related to the implementation of the Plan.

This Plan is an enabling document that allows the federal, provincial, and First Nations partners to explore, develop, test, and implement new priorities, structures, and processes over time. Most importantly, this Plan supports the development of local health plans for all BC First Nations and recognizes the fundamental importance of community solutions and approaches.

Vision

It is the collective vision of the Province of British Columbia, the Government of Canada as represented by the Department of Health ("Health Canada") and the First Nations Leadership Council that the health and well-being of First Nations is improved, the gaps in health between First Nations people and other British Columbians are closed, and First Nations are fully involved in decision-making regarding the health of their peoples.

Components of this vision include:

- Each First Nation and mandated health organization will have a comprehensive health plan that will be a foundational document for the design of community health services and the creation of working partnerships with governments and health service providers.

- First Nations health services will be delivered in a manner that effectively meets the needs, priorities and interests of First Nations communities and First Nations individuals, regardless of their residency, and recognizes the fundamental importance of community solutions and approaches.
- First Nations individuals in all regions of British Columbia will have access to quality health services comparable to those available to other Canadians living in similar geographic locations.
- First Nations and their mandated health organizations will be central to the design and delivery of all health services at the community level. These health services will be coordinated with other community-based services.
- Health services delivered by First Nations, when appropriate, will be effectively linked to and coordinated with provincially-funded services, such as those provided by the regional health authorities.
- First Nations health services will be delivered through a new governance structure that leads to improved accountability and control of First Nations health services by First Nations.
- Health Canada, in cooperation with the First Nations Leadership Council and the Province of British Columbia, will continue to evolve its role from that of a *designer and deliverer* of First Nations health services to that of *funder* and *governance partner*, based on priorities set in the annual workplan and the ongoing assessment of progress. Federal and provincial support for First Nations delivered services will be provided through more flexible funding mechanisms with streamlined reporting requirements and accountability measures.
- First Nations, Health Canada and the provincial government (including its regional health authorities) will maintain an ongoing collaborative relationship based on respect, reconciliation and recognition of each other's roles as governance partners.

Principles

The implementation of this Plan, including the creation of a new governance structure for First Nations health services, will be based on the following principles:

Respect and Recognition:

- The Parties acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities, and will seek to remove impediments to progress by establishing effective working relationships.
- Cultural knowledge and traditional health practices and medicines will be respected as integral to the well being of First Nations.
- Health services will reflect the diversity, interests and vision of First Nations for the delivery of health and other community services and lead to improved health status for individuals, families and communities.
- The coordination of federally and provincially-funded health programs and services will be more effective and include the increased participation of First Nations in the governance, management and delivery of services.

Commitment to Action:

- Health and wellness for First Nations encompasses the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family and community. Although the present Plan focuses on health programs and services, it is recognized that the way forward will require a joint commitment to deal with the root causes and structural issues causing socio-economic gaps.
- All Parties to this Plan will contribute financially and/or in kind to the implementation of the new First Nations health service governance and delivery structures and other elements of the Plan, based on mandates, available resources and authorities.
- Duplication will not occur and a parallel health service delivery structure will not be created.

Nuture the Relationship:

- The actions of the Parties will be based on *reciprocal accountability*; each Party will be responsible to the others for obligations and commitments under this Plan. The Parties respect the need for, and commit to, the evaluation of progress and initiatives.
- The capacity development requirements of the First Nations health sector will be paramount, through planned growth, knowledge and skill transfer. Federal and provincial service delivery infrastructure will not be expanded or enhanced without consideration of viable First Nations alternatives.

Transparency:

- The Parties will discuss potential changes to programs and services (including the transfer of programs and services) that might impact other Parties.
- Information will be shared between the Parties in an open and timely manner, subject to and in accordance with law.

Governance, Relationships and Accountability

A new structure for the governance of First Nations health services in British Columbia, which will initially include regional health planning and administration as well as health design, delivery and accountability, will be created and implemented to reflect the service delivery needs of First Nations and to define results to be achieved. The new governance structure for First Nations health services in British Columbia will have four essential components:

A *First Nations Health Governing Body* will be developed through the work of a tripartite committee within three years to: design a new governance structure; seek ratification of this governance structure by the Parties; and oversee the implementation planning. The Governing Body will provide for the effective participation of First Nations in: enacting policies; identifying the results to be achieved in the delivery of programs; allocating resources; establishing service standards; implementing ongoing reciprocal accountability requirements; and other key functions of governance. In the interim, the Parties will support a process for First Nations to have greater control over augmented resources dedicated to improve health services.

A *First Nations Health Council*, created by BC First Nations, with the mandate to: serve as the advocacy voice of First Nations on health-related matters; to support all First Nations in achieving their health priorities, objectives and initiatives; to participate in federal and provincial government health policy and planning processes; and to provide leadership in the implementation of this Plan.

A tripartite *First Nations Health Advisory Committee*, as identified in the TCA:FNHP, will review and monitor the Aboriginal Health Plans of the regional health authorities, monitor health outcomes in First Nations communities, and recommend actions to the Parties on closing health gaps.

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

Health Promotion/Disease and Injury Prevention

The actions identified in the TCA: FNHP will form the basis of a tripartite health promotion and disease and injury prevention strategy. This strategy will be developed and implemented within the next three years, and will identify joint funding sources, responsibility for action items, and delivery outcomes.

Health Services

British Columbia is responsible for the provision of health services to all citizens of the province through its regional health authorities. Health Canada supports First Nations through a range of public health programs and benefits intended to improve population health and ensure effective access to the health care system. The TCA: FNHP identifies some specific projects and activities intended to close jurisdictional and health gaps and optimize funding opportunities for innovations that will make a greater difference in First Nations communities.

A multi-jurisdictional health planning framework will be developed that provides service delivery linkages between goals and activities described in First Nations' community health plans with those of regional health authority service plans. Service delivery planning will be ongoing and evolve over time.

Performance Tracking

The *First Nations Health Plan Memorandum of Understanding* and the *Transformative Change Accord: First Nations Health Plan* identify seven "performance indicators" that will be used to track progress on closing the gap in health status between First Nations people and other citizens of British Columbia. Other key indicators will also be identified as appropriate, including the measurement of new and improved health governance, management, and service delivery relationships at all levels.

First Nations, British Columbia, and Health Canada have worked closely for many years and will continue to work collaboratively to collect data and report on health outcome indicators. The Parties will also work jointly to measure progress in key areas on the advice of the Health Advisory Committee, the First Nations Health Council, and the association of health directors and other health professionals.

Implementation, Planning, Oversight and Community Engagement

A workplan for this Tripartite First Nations Health Plan will be developed and updated by the Parties on an annual basis and a report on progress will be prepared every three years, with recommendations for improvement. An initial workplan will be developed within six months of the release of this Plan and will incorporate input from First Nations provided at the first BC *First Nations Health Forum: Gathering Wisdom for a Shared Journey*, held on April 10-11, 2007. The finalization of this workplan will not impede implementation of key action items in the interim.

High level engagement of all the Parties to the Plan will be managed through annual Principals' meetings between Ministers of Health and the First Nations Leadership Council, to review progress.

Engagement with First Nations, their mandated health organizations, and health care providers on this Plan will be achieved through regularly scheduled province-wide and regional Forums and a comprehensive communications strategy.

Funding

The implementation of this Tripartite Plan will be partially funded through current federal and provincial budget allocations. The Parties to this Plan acknowledge that additional funding will be required and agree to explore ways to sustain the implementation of the Plan through new investment over the term of the Plan.

Term of Plan

The First Nations Tripartite Health Plan covers the period from June 1, 2007 to May 31, 2017.

Appendices

Appendix A: *The Transformative Change Accord: First Nations Health Plan*
Appendix B: *First Nations Health Plan Memorandum of Understanding*

Approved by the Parties on the 27th day of May, 2007,
and signed on the 11th day of June, 2007.

Government of Canada

Honourable Tony Clement
Minister of Health

Witness

Government of British Columbia

Honourable Gordon Campbell
Premier

Witness

First Nations Leadership Council

The First Nations Summit

Grand Chief Edward John

Chief Judith Sayers

Dave Porter

BC Assembly of First Nations

Regional Chief A-in-chut Shawn Atleo

Union of BC Indian Chiefs

Grand Chief Stewart Phillip

Chief Robert Shintah

Chief Lynda Price

Canada

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NEWS RELEASE

For Immediate Release
August 31, 2009

Government of Canada, Government of British Columbia, and First Nations Health Council Reaffirm Commitment to Tripartite First Nations Health Plan

VICTORIA - The Honourable Leona Aglukkaq, Federal Minister of Health, the Honourable Ida Chong, British Columbia's Minister of Healthy Living and Sport, and representatives of the British Columbia First Nations Health Council (FNHC) met today to receive an update on the progress of the BC Tripartite First Nations Health Plan, and to reaffirm their commitment to this agreement.

"This meeting today is an important step in moving forward. Working together, the Government of Canada, the Province of British Columbia and the First Nations Health Council will ensure the success of the BC Tripartite First Nations Health Plan," said Minister Aglukkaq. "Our goal is to enable First Nations to take the lead in designing and delivering healthcare for BC First Nations, thereby ensuring culturally-relevant and more effective health services that improve the health and well-being of BC First Nations."

Signed on June 11, 2007, the Tripartite First Nations Health Plan is intended to improve health services and enhance First Nations involvement in the delivery of health services and to help close the gaps in health status between First Nations people and other British Columbians. The Plan is already generating tangible and measureable changes that are positively impacting the health outcomes of BC First Nations in key areas such as mental health, e-health, and maternal and child health. First Nations are taking an active role in creating culturally appropriate health promotion initiatives.

The management of H1N1 for BC First Nations demonstrates how new approaches are generating enhanced outcomes. Since it was formed in July, a Tripartite H1N1 Health Partners Group co-chaired by two First Nations physicians, Dr. Evan Adams and Dr. Shannon Waters, has been proactively responding to the pandemic in British Columbia and is completing an Action Plan for remote and rural First Nations communities to address their unique needs.

"The Province is committed to the continued partnership with First Nations and the federal government to realize the goals of the Tripartite First Nations Health Plan in reducing the gap in health status between First Nations and other British Columbians," said Minister Chong. "This tripartite plan leads the way in Canada, and the relationships that exist because of it have enabled a coordinated and efficient response by partners to the H1N1 issue."

The three partners will also work together to create a new governance structure that will give First Nations control of health services for First Nations, and promote better integration and coordination of federally and provincially funded health services.

.../2

"H1N1 is a great concern for First Nations peoples. We must ensure that we continue working together to address any service gaps in order to help protect First Nations people as an outbreak occurs," said Grand Chief Ed John, First Nations Health Council, Interim Health Governance Committee Co-Chair. "This will require both governments to align their efforts in a manner that works with and supports First Nations communities."

"The prospect of a new governance structure that recognizes the role of First Nations in the governance of their own health services is a positive one. However, this will require adequate and sustained resourcing to ensure that the provision of First Nations health services are effective and efficient," said Grand Chief Doug Kelly, First Nations Health Council, Interim Health Governance Committee Co-Chair.

"This inaugural meeting today signals a positive beginning in our collective commitment to ensure sustained political will and collaboration of all parties involved. We have many pressing issues in front of us, and our relationships must remain strong if we are to ensure improved health outcomes for First Nations," said Chief Lydia Hwitsum, First Nations Health Council Co-Chair. "We look forward to meeting frequently to further strengthen the implementation and success of this important plan."

Moving forward, all parties confirmed their intention to work together to meet the goal of an agreement on a new governance structure. They also committed to maintaining and enhancing their partnership in providing better health services to First Nations in British Columbia.

-30-

Media Enquiries:

Également disponible en français

Josée Bellemare
Office of the Honourable Leona Aglukkaq
Federal Minister of Health
(613) 957-0200

Jeff Rud
BC Ministry of Healthy Living and Sport
(250) 952-2387

Heather Squire
First Nations Health Council
(604) 787-4159

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FILE COPY

PLEASE "D" MANUAL CHEQUE

Attn: Kevin Brady 952-1754

COPY

MARCH 19, 2008

Accounts Payable
Ministry of Health

Please generate a payment of **$1,000,000** to the following agency:

FIRST NATION SUMMIT SOCIETY
1200- 100 PARK ROYAL SOUTH
WEST VANCOUVER, BC V7T 1A2

Supplier Number:	843750	Location Number:	001
Invoice Number:	GRANT$1M	Invoice Date:	MARCH 19/08

Cheque stub information: PROVIDE FUNDING TO THE FIRST NATIONS SUMMIT SOCIETY TO ENHANCE FIRST NATIONS HEALTH

Client:	026	Expense Authority:	ANDREW HAZELWOOD
Resp:	66584		
Service Line:	45434		
STOB:	7703		
Project:	6600000		

Grant has been approved and payment is required at this time.

Date MARCH 19/08

Qualified Receiver JUNE CARDIN
Program Contact Name Lori Isaac / Deborah Schwartz

BRITISH COLUMBIA

COPY

Transfer Agreement

THIS AGREEMENT made the 10th day of March, 2008.

BETWEEN:

Ministry of Health (the Ministry)
1515 Blanshard Street
Victoria BC V8W 3C8

OF THE FIRST PART

AND:

First Nations Summit Society
1200-100 Park Royal South
West Vancouver BC V7T 1A2

OF THE SECOND PART

WHEREAS:

The Ministry has the authority and wishes to provide a grant to the First Nations Summit Society, based on the terms and conditions hereinafter set forth:

The First Nations Summit Society is eligible for the grant as determined by the Ministry.

NOW THEREFORE in consideration of the premises and covenants and agreements set out in this Agreement and for other good and valuable consideration (the receipt and sufficiency of which is hereby acknowledged by the parties), the parties agree as follows:

PAYMENT OF FUNDS

The Ministry will disburse $1,000,000 to the First Nations Summit Society on the signing this agreement.

or become obligated to the First Nations Summit Society pursuant to this Agreement for an amount exceeding, in the aggregate, $1,000,000.

TERMS AND CONDITIONS

Notwithstanding any other provision of this Agreement, the provision of the grant pursuant to this Agreement is for the purposes outlined below.

PURPOSES

The Ministry will provide funding to the First Nations Summit Society to enhance First Nations health.

The First Nations Summit Society agrees that the funding will be used for these purposes.

Upon request, the First Nations Summit Society will provide to the Ministry, a report in the form and manner prescribed by the Ministry, showing the expenditures made to date and the estimated future expenditures, from the $1,000,000 funding provided by the Ministry.

IN WITNESS WHEREOF the parties hereto have executed this Agreement the day and year first above written.

SIGNED AND DELIVERED on behalf of the Ministry of Health	SIGNED AND DELIVERED on behalf of The First Nations Summit Society
Andrew Hazlewood Assistant Deputy Minister Population Health and Wellness Ministry of Health	Howard Grant Executive Director First Nations Summit Society

COPY

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PROVINCE OF BRITISH COLUMBIA GENERAL ACCOUNT

10420692

CREDIT UNION CENTRAL OF BRITISH COLUMBIA
1441 CREEKSIDE DRIVE
VANCOUVER BC V6J 4S7

DATE 2008 03 26
Y Y Y Y M M D D

PAY ONE MILLION DOLLARS 00CENTS

$***1,000,000.00

TO FIRST NATIONS SUMMIT SOCIETY
1200-100 PARK ROYAL ST S
WEST VANCOUVER BC V7T 1A2

00060

S17

BRITISH COLUMBIA GENERAL ACCOUNT

REMITTANCE STATEMENT - Detach before presenting cheque for cashing

Province of British Columbia
(HE)

CHEQUE NUMBER **10420692**

CHEQUE DATE Y 2008 M Mar D 26

Vendor Number: 843750 002

INVOICE NUMBER	INVOICE DATE	INVOICE AMOUNT	DESCRIPTION
GRANT$1M	Mar 19 2008	1,000,000.00	Grant Re FUNDING TO THE FIRST NATIONS SUMMIT SOCIETY TO ENHANCE FIRST NATIONS HEALTH TRANSFER AGREEMENT DATED MAR 10, 2008

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Internal Use:
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BC Government is not subject to GST

For Payment Inquiries please contact ENQUIRY BC
Victoria: 250 387-6121 Vancouver: 604 660-2421 Elsewhere in BC: 1-800-663-7867

BRITISH COLUMBIA

Transfer Agreement

THIS AGREEMENT made the 23rd day of March, 2007.

BETWEEN:

Ministry of Health (the Ministry)
1515 Blanshard Street
Victoria, B.C. V8W 3C8

OF THE FIRST PART

AND: Howard Grant
Executive Director
First Nations Summit Society
Suite 1200 - 100 Park Royal South
West Vancouver, B.C. V7T 1A2

OF THE SECOND PART

WHEREAS:

The Ministry has the authority and wishes to provide a grant to the First Nations Summit Society, based on the terms and conditions hereinafter set forth:

The First Nations Summit Society is eligible for the grant as determined by the Ministry.

NOW THEREFORE in consideration of the premises and covenants and agreements set out in this Agreement and for other good and valuable consideration (the receipt and sufficiency of which is hereby acknowledged by the parties), the parties agree as follows:

PAYMENT OF FUNDS

The Ministry will disburse $9,500,000 to the First Nations Summit Society on the signing this agreement.

Notwithstanding any other provision of this Agreement, in no event will the Ministry be or become obligated to the First Nations Summit Society of British Columbia pursuant to this Agreement for an amount exceeding, in the aggregate, $9,500,000.

TERMS AND CONDITIONS

Notwithstanding any other provision of this Agreement, the provision of the grant pursuant to this Agreement is for the purposes outlined below.

PURPOSES

The Ministry will provide funding to the First Nations Summit Society to enhance First Nations health.

The First Nations Summit Society agrees that the funding will be used for these purposes.

Upon request, the First Nations Summit Society will provide to the Ministry, a report in the form and manner prescribed by the Ministry, showing the expenditures made to date and the estimated future expenditures, from the $9,500,000 funding provided by the Ministry.

IN WITNESS WHEREOF the parties hereto have executed this Agreement the day and year first above written.

SIGNED AND DELIVERED on behalf of the Ministry of Health

Andrew Hazlewood
Assistant Deputy Minister
Population Health and Wellness
Ministry of Health

SIGNED AND DELIVERED on behalf of the First Nations Summit Society

Howard Grant
Executive Director
First Nations Summit Society

BRITISH COLUMBIA
The Best Place on Earth

Transfer Agreement

THIS AGREEMENT made the 6th day of March, 2008.

BETWEEN:

Ministry of Health
1515 Blanshard Street
Victoria BC V8W 3C8
Fax: 250 952-1573

OF THE FIRST PART

AND:

First Nations Summit Society
1200 100 Park Royal South
West Vancouver BC V7T 1A2

OF THE SECOND PART

WHEREAS:

The Ministry of Health (the Ministry) has the authority and wishes to provide a grant to the First Nations Summit Society, based on the terms and conditions hereinafter set forth:

The First Nations Summit Society is eligible for the grant as determined by the Ministry.

NOW THEREFORE in consideration of the premises and covenants and agreements set out in this Agreement and for other good and valuable consideration (the receipt and sufficiency of which is hereby acknowledged by the parties), the parties agree as follows:

PAYMENT OF FUNDS

The Ministry will disburse $6,000,000 to the First Nations Summit Society on the signing this agreement.

Not withstanding any other provision of this Agreement, in no event will the Ministry be or become obligated to the First Nations Summit Society pursuant to this Agreement for an amount exceeding, in the aggregate, $6,000,000.

TERMS AND CONDITIONS

Notwithstanding any other provision of this Agreement, the provision of the grant pursuant to this Agreement is for the purposes outlined below.

PURPOSES

The Ministry will provide funding to the First Nations Summit Society to enhance First Nations Health.

The first Nations Summit Society agrees that the funding will be used for these purposes.

Upon request, the First Nations Summit Society will provide to the Ministry, a report in the form and manner prescribed by the Ministry, showing the expenditures made to date and the estimated future expenditures, from the $6,000,000 funding provided by the Ministry.

IN WITNESS WHEREOF the parties hereto have executed this Agreement the day and year first above written.

SIGNED AND DELIVERED on behalf of the Ministry of Health

Andrew Hazlewood
Assistant Deputy Minister
Population Health and Wellness
Ministry of Health

SIGNED AND DELIVERED on behalf of the First Nations Summit Society

Howard Grant
Executive Director
First Nations Summit Society

BRITISH COLUMBIA
The Best Place on Earth

PLEASE "D" MANUAL CHEQUE

FILE COPY

Attn: Kevin Brady 952-1754

MARCH 19, 2008

Accounts Payable
Ministry of Health

Please generate a payment of **$6,000,000** to the following agency:

FIRST NATION SUMMIT SOCIETY
1200- 100 PARK ROYAL SOUTH
WEST VANCOUVER, BC V7T 1A2

Supplier Number: 843750 Location Number: 001
Invoice Number: GRANT$6M Invoice Date: MARCH 19/08

Cheque stub information: PROVIDE FUNDING TO THE FIRST NATIONS SUMMIT SOCIETY TO ENHANCE FIRST NATIONS HEALTH

Client:	026	Expense Authority: ANDREW HAZELWOOD
Resp:	66584	
Service Line:	45434	
STOB:	7703	
Project:	6600000	

Grant has been approved and payment is required at this time.

Date MARCH 19/08

Qualified Receiver JUNE CARDIN
Program Contact Name Lori Isaac / Deborah Schwartz

BRITISH COLUMBIA BC 150 YEAR The Best Place on Earth

PROVINCE OF BRITISH COLUMBIA GENERAL ACCOUNT

66584

10420693

CREDIT UNION CENTRAL OF BRITISH COLUMBIA
1441 CREEKSIDE DRIVE
VANCOUVER BC V6J 4S7

DATE 2008 03 26 (Y Y Y Y M M D D)

PAY SIX MILLION DOLLARS 00CENTS $***6,000,000.00

TO FIRST NATIONS SUMMIT SOCIETY
1200-100 PARK ROYAL ST S
WEST VANCOUVER BC V7T 1A2

00061

S17

BRITISH COLUMBIA
GENERAL ACCOUNT

REMITTANCE STATEMENT - Detach before presenting cheque for cashing

Province of British Columbia
(HE)

CHEQUE NUMBER **10420693**

CHEQUE DATE Y 2008 M Mar D 26

Vendor Number: 843750 002

INVOICE NUMBER	INVOICE DATE	INVOICE AMOUNT	DESCRIPTION
GRANT$6M	Mar 19 2008	6,000,000.00	Grant Re FUNDING TO THE FIRST NATIONS SUMMIT SOCIETY TO ENHANCE FIRST NATIONS HEALTH TRANSFER AGREEMENT DATED MAR 6, 2008

5166488

Internal Use:
Code: D

BC Government is not subject to GST

For Payment Inquiries please contact ENQUIRY BC
Victoria: 250 387-6121 Vancouver: 604 660-2421 Elsewhere in BC: 1-800-663-7867