Health Canada and the Public Health Agency of Canada
Santé Canada et l'Agence de la Santé publique du Canada

Evaluation of the First Nations BC Tripartite Contribution Agreements

2007-08 to 2011-12

Final Report

March, 2013

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Management Response

Evaluation of the First Nations BC Tripartite Contribution Agreements

Fiscal Year Completed: 2012/13

Formal recommendations are not being proposed for this evaluation given that the contribution agreements are winding down and Health Canada will evolve into its role as funder and governance partner, with ongoing commitments outlined in the Framework Agreement and the proposed Canada Funding Agreement. Health Canada's ongoing commitments include: participating in and supporting the new governance relationship; fostering integration between First Nations and provincial health programming where possible; supporting capacity development of BC First Nations; and, supporting robust reporting among the three partners.

Based on the findings and conclusions outlined in this evaluation report, the department is aware that there are lessons learned that will be valuable to consider in future tripartite activities.

Conclusions	Management Response	Further Considerations/ Comments/ Action
1. Relevance Health Canada's contribution funding to this recipient enabled its engagement in tripartite activities and its movement assuming the design, management and delivery of First Nations health programming in BC. 2. Performance: Effectiveness The FNHA has advanced in establishing the appropriate frameworks, operational structures and planning processes toward its transition and implementation.	Management agrees with the conclusions of this evaluation, as this funding significantly contributed to: the evolution and success of the First Nations Health Authority; the overall engagement of BC First Nations' in the tripartite process; the completion of three-party health action projects; and the improved integration between BC First Nations and the Province of BC. This support has resulted in the signing and implementation of the BC Tripartite Framework Agreement on First Nation Health Governance. The first of its kind, the Framework Agreement establishes a new First Nations health governance structure in BC, shifting the responsibility for design, management, funding and delivery of BC First Nations health programming from the federal government to the new First Nations Health Authority.	The department's investment and engagement in First Nations health collaboration generally, including collaboration with provincial and First Nations partners, contributes to the building of First Nations' capacity and remains a priority for the department. For the BC Tripartite initiative, management is confident in the capacity of the First Nations Health Authority and the strength of the tripartite partnership to continue to overcome any challenges before, during, or after transfer and as roles and responsibilities evolve. After transfer, HC will continue in a governance role to support the First Nations Health Authority. The

Conclusions	Management Response	Further Considerations/ Comments/ Action
3. Performance: Economy and Efficiency The contribution agreements demonstrate a sound investment strategy that supports the success of the recipient's involvement in the Tripartite Initiative.	It also engages the Province of BC in the ongoing integration of services. The department anticipates that the ongoing collaboration and strong working relationship among the parties has been instrumental to the success of the initiative thus far and will continue to support a smooth, effective, and efficient transition. The partners continue to jointly identify challenges as they arise and determine workable solutions through established mechanisms and ongoing committees. Management is confident in the capacity of the FNHA and the strength of the tripartite partnership to continue to overcome any challenges before, during, and after transfer and as roles and responsibilities evolve. FNIHB will apply the many lessons learned from these contribution agreements to inform future collaborative work with provinces and First Nations partners, especially as they relate to its new Strategic Plan and goals of establishing collaborative approaches to health service delivery, and supporting the capacity of First Nations involving First Nations in decision-making.	Framework Agreement and other accords, plans, and agreements establish a series of mechanisms, committees, and meetings to foster ongoing engagement among the parties. Based on the findings and conclusions outlined in this evaluation report, the department is aware that there are lessons learned that will be valuable to consider in future tripartite activities.

ACRONYMS

BC	British Columbia
FA	Framework Agreement
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHS	First Nations Health Society
FNIH	First Nations and Inuit Health (Regions)
FNIHB	First Nations and Inuit Health Branch
GoC	Government of Canada
HC	Health Canada
MOU	Memorandum of Understanding
NCR	National Capital Region
PAA	Program Alignment Architecture
RFP	Request for Proposals
RHA	Regional Health Authority (Province of BC)
RPP	Report on Plans and Priorities
TCA: FNHP	Transformative Change Accord: First Nations Health Plan
TFNHP	Tripartite First Nations Health Plan

Executive Summary

Evaluation Purpose and Methodology

As part of the British Columbia (BC) Tripartite Initiative, Health Canada entered into two contribution agreements with the BC First Nations Health Authority (FNHA).[1] These agreements (2007-08 and 2010-11) totaled $56M and supported the FNHA's efforts to participate in the BC Tripartite Initiative, as the representative organization for all BC First Nation communities, and enabled it to engage in the tripartite activities, develop its capacity, and evolve its operations.

This evaluation was added to the Health Canada Departmental Evaluation Plan (DEP) in fiscal year 2012-13 for completion by March 2013. This was in response to the government's conditions for approval to access funds for the second contribution agreement ($17M in 2011) and ensures compliance with the *Financial Administration Act* requirement for grants and contributions evaluation coverage (every five years).

The evaluation covered both the relevance and performance of Health Canada's contribution agreements with this recipient. Specifically, the evaluation focused on the achievement of immediate and intermediate outcomes. In addition, the evaluation highlighted challenges and lessons learned from the BC Tripartite Initiative experience that could be applied to Health Canada's role in potential future collaboration with First Nation and provincial partners.

BC Tripartite Contribution Agreements

Health Canada's BC Tripartite contribution agreements were unique in that they represented an "initiative" and not a traditional program within Health Canada – they were the result of many years of negotiation and discussion among three partners which included the Government of Canada (GoC), the provincial government of BC, and BC First Nations.

The evaluation of Health Canada's BC Tripartite contribution agreements focused on the impact the funding had in enabling BC First Nations to transition to full partnership in governance and program delivery, and creating a new BC First Nations Health Authority to assume the design, management, and delivery of First Nations health programming in alignment with the provincial health system.

Work on the Initiative began on a bilateral basis between BC First Nations and the Government of BC in 2005, before the federal government joined the discussions in 2006. Initial federal effort and investment was intended to support First Nation engagement in the overall tripartite process and build the relationship among the parties.

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[1] For the purposes of this report, the name First Nations Health Authority will be used throughout when referring to the operational entity that received contribution funding.

Summary of Evaluation Findings, Conclusions and Implications

Findings: Relevance

There was a relevant need to support the BC Tripartite Initiative with contribution funding in order to enable BC First Nations engagement in the BC tripartite initiative and involvement in designing, planning and implementing BC First Nation health service delivery.
The BC Tripartite contribution agreements were aligned with federal government and Health Canada priorities and fulfilled federal roles and responsibilities to support and strengthen BC First Nation participation in policy and planning for the delivery of health services.

Findings: Performance

The evaluation found that the progress made to date on the expected immediate outcomes included: the establishment of collaborative health program approaches and mechanisms between delivery partners (BC First Nations, and the federal and provincial governments, including provincial Regional Health Authorities); increased capacity among BC First Nations to collaborate on the implementation of the BC Tripartite First Nations Health Plan; the establishment of mechanisms for BC First Nations involvement in decision-making for health planning and service delivery for BC First Nations; an innovative and integrated relationship and partnership between tripartite partners; identification of BC First Nations health priorities, objectives and initiatives; and the creation of mechanisms for the participation of BC First Nations in federal and provincial government health policy and program planning processes.

Expected intermediate outcomes are being achieved as demonstrated by: signing of a legally-binding tripartite governance agreement (October 13, 2011); the establishment of a new First Nations health governance structure in BC; and, evidence showing that the transition of program design, management and delivery is on track for completion in 2013.

The analysis of resource allocation and utilization found that the resources invested in the FNHA had a positive impact on progress made toward the achievement of the expected outcomes.

The literature review illustrated that investments supporting capacity building, collaboration and partnership tend to ensure success in partnerships between government and community initiatives. Analysis of departmental financial data illustrated that the contribution agreements provided investments in the appropriate areas to support the BC Tripartite Initiative.

Conclusions

Health Canada's contribution funding to this recipient enabled its engagement in tripartite activities and its movement towards assuming the design, management and delivery of First Nations health programming in BC.

The FNHA has advanced in establishing the appropriate frameworks, operational structures and planning processes toward its transition and implementation, although some operational challenges remain.

The contribution agreements demonstrate a sound investment strategy that supports the success of the recipient's involvement in the Tripartite Initiative.

Implications
Formal recommendations are not being proposed given that the contribution agreements are winding down and Health Canada will evolve into its role as funder and governance partner, with ongoing commitments outlined in the Framework Agreement and the proposed Canada Funding Agreement.

Health Canada's ongoing commitments include: participating in and supporting the new governance relationship; fostering integration between First Nations and provincial health programming where possible; supporting capacity development of BC First Nations; and, supporting robust reporting among the three partners.

Based on the findings and conclusions outlined in this evaluation report, the department is aware that there are lessons learned that will be valuable for the department to consider in future tripartite activities.

Evaluation Lessons Learned

The consistent partnership, commitment and shared vision of all players were instrumental to the progress made to date. The evaluation found many positive achievements and innovative processes that led to the successes and progress made to date. These included a tripartite process that:

- Built on previous tripartite partnership efforts to establish frameworks to address FN health governance and included lessons learned from other jurisdiction;
- Established a common, shared vision from the outset;
- Fostered trust and strengthened relationships between partners through active, committed and passionate engagement by high-ranking officials;
- Outlined partnership roles and responsibilities in formal collaborative agreements;
- Established a governance body and operational mechanisms to develop and implement actions with clear, concise delegation of power, while ensuring the separation of political and operational mandates as well a timely decision-making;
- Named a third-party independent chair at the early stages allowing for transparency and cultivating strong partnerships;
- Established strong communications protocols and frequent dialogue; and
- Ensured participation and engagement of skilled and knowledgeable individuals as appropriate.

The evaluation highlights many lessons learned reflecting the various stages of the tripartite initiative over the last several years. These could be applied to future partner collaboration, capacity building, and integration. The lessons summarized below include the need to ensure:

- Improved emergency management and pandemic planning at the community level.
- Sufficient time and resources to engage in constructive consultations with multiple stakeholders.
- Staff training to facilitate integration of provincial and on-reserve health programming;
- Regular and free flow of information among the partners.
- Consideration of each party's decision-making processes and timelines.
- Support for early development of First Nations' planning and risk management functions.

- Collaborative efforts to integrate service delivery, including changing established ways of delivering health care, communicating and engaging in culturally appropriate ways, and identifying priorities.

Table 1: Evaluation Findings, Conclusions and Implications

<table>
<tr><th colspan="3">Findings</th><th>Conclusions</th><th>Implications</th></tr>
<tr><td rowspan="2">Relevance</td><td rowspan="2"></td><td>There was a relevant need to support the BC Tripartite Initiative with contribution funding in order to enable BC First Nations engagement in the BC tripartite initiative and involvement in designing, planning and implementing BC First Nation health service delivery.</td><td rowspan="2">Health Canada’s contribution funding to this recipient enabled its engagement in tripartite activities and its movement towards assuming the design, management and delivery of First Nations health programming in BC.</td><td rowspan="6">Formal recommendations are not being proposed for this evaluation given that the contribution agreements are winding down and Health Canada will evolve into its role as funder and governance partner, with ongoing commitments outlined in the Framework Agreement and the proposed Canada Funding Agreement.

Health Canada’s ongoing commitments include: participating in and supporting the new governance relationship; fostering integration between First Nations and provincial health programming where possible; supporting capacity development of BC First Nations; and, supporting robust reporting among the three partners.

Based on the findings and conclusions outlined in this evaluation report, the department is aware that there are lessons learned that will be valuable to consider in future tripartite activities.</td></tr>
<tr><td>The BC Tripartite contribution agreements were aligned with federal government and Health Canada priorities and fulfilled federal roles and responsibilities to support and strengthen BC First Nation participation in policy and planning for the delivery of health services.</td></tr>
<tr><td rowspan="4">Performance</td><td rowspan="2">Effectiveness</td><td>The evaluation found that the progress made to date on the expected immediate outcomes included: the establishment of collaborative health program approaches and mechanisms between delivery partners (BC First Nations, and the federal and provincial governments, including provincial Regional Health Authorities); increased capacity among BC First Nations to collaborate on the implementation of the BC Tripartite First Nations Health Plan; the establishment of mechanisms for BC First Nations involvement in decision-making for health planning and service delivery for BC First Nations; an innovative and integrated relationship and partnership between tripartite partners; identification of BC First Nations health priorities, objectives and initiatives; and creation of mechanisms for the participation of BC First Nations in federal and provincial government health policy and program planning processes.</td><td rowspan="2">The FNHA has advanced in establishing the appropriate frameworks, operational structures and planning processes toward its transition and implementation.</td></tr>
<tr><td>Expected intermediate outcomes are being achieved as demonstrated by: signing of a legally-binding tripartite governance agreement (October 13, 2011); the establishment of a new First Nations health governance structure in BC; and, evidence showing that the transition of program design, management and delivery is on track for completion in 2013.</td></tr>
<tr><td rowspan="2">Efficiency and Economy</td><td>The analysis of resource allocation and utilization found that the resources invested in the FNHA had a positive impact on progress made toward the achievement of the expected outcomes.</td><td rowspan="2">The contribution agreements demonstrate a sound investment strategy that supports the success of the recipient’s involvement in the Tripartite Initiative.</td></tr>
<tr><td>The literature review illustrated that investments supporting capacity building, collaboration and partnership tend to ensure success in partnerships between government and community initiatives. Analysis of departmental financial data illustrated that the contribution agreements provided investments in the appropriate areas to support the BC Tripartite Initiative.</td></tr>
</table>

1. EVALUATION PURPOSE

Purpose
This evaluation assessed the relevance and performance (effectiveness, efficiency and economy) of the activities undertaken and results achieved by Health Canada's investment in the British Columbia (BC) Tripartite Initiative for the period of 2007-2008 to 2011-2012. The evaluation also identified gaps, barriers to success, and success stories related to the BC Tripartite contribution agreements, particularly in the context of lessons learned for future tripartite collaborative activities.

The BC Tripartite Initiative was supported by Health Canada, through its First Nations and Inuit Health Branch (FNIHB), which provided contribution funding to the BC First Nations Health Authority[2] ($29M in 2007-2008 with a subsequent $10M amendment, as well as an additional $17M approved by the federal government in December 2011).

This evaluation was requested in 2011, as part of the conditions for government approval of the $17M funding. As per Health Canada's 5-Year Departmental Evaluation Plan (DEP), the evaluation schedule listed the BC Tripartite contribution agreements as an evaluation requirement for 2012-2013.

2. BC TRIPARTITE DESCRIPTION

2.1. BC Tripartite Profile

Health Canada's BC Tripartite contribution agreements were unique in that they represented an "initiative" and not a traditional program within Health Canada. The initiative was the result of many years of negotiation and discussion between three jurisdictional partners: the GoC, the Government of BC, and BC First Nations[3]. This was the first time Health Canada had implemented contribution agreements for an initiative of this nature.

Health Canada's support for this initiative was reflected through two contribution agreements with only one recipient: the BC First Nations Health Authority. These contribution agreements were unique to the Canadian context in that they focused on enabling BC First Nations to transition to full partnership in governance and program delivery. The agreements also allowed for the creation of a new health governance structure in which the BC FNHA will assume the design, management, and delivery First Nations health programming in BC and integrate program delivery with the provincial health system.

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2 The BC First Nations Health Society was originally called the BC First Nations Health Summit Society, and has evolved to become the BC interim First Nations Health Authority (iFNHA) and subsequently the First Nations Health Authority (FNHA). For the purposes of this report, the organization will be referred throughout as the First Nations Health Authority (FNHA).

3 Ibid

The BC Tripartite Initiative has been evolving for many years (see Appendix A for details). Work began on a bilateral basis between BC First Nations and the Government of BC in 2005, before the federal government joined the discussions in 2006. Initial federal effort and investment was intended to support First Nation engagement in the overall tripartite process, and to build the relationship among the parties. The ultimate goal of the Initiative, and the related initial contribution funding, was not pre-determined beyond providing overall capacity support for the implementation of the 2007 BC Tripartite First Nations Health Plan.

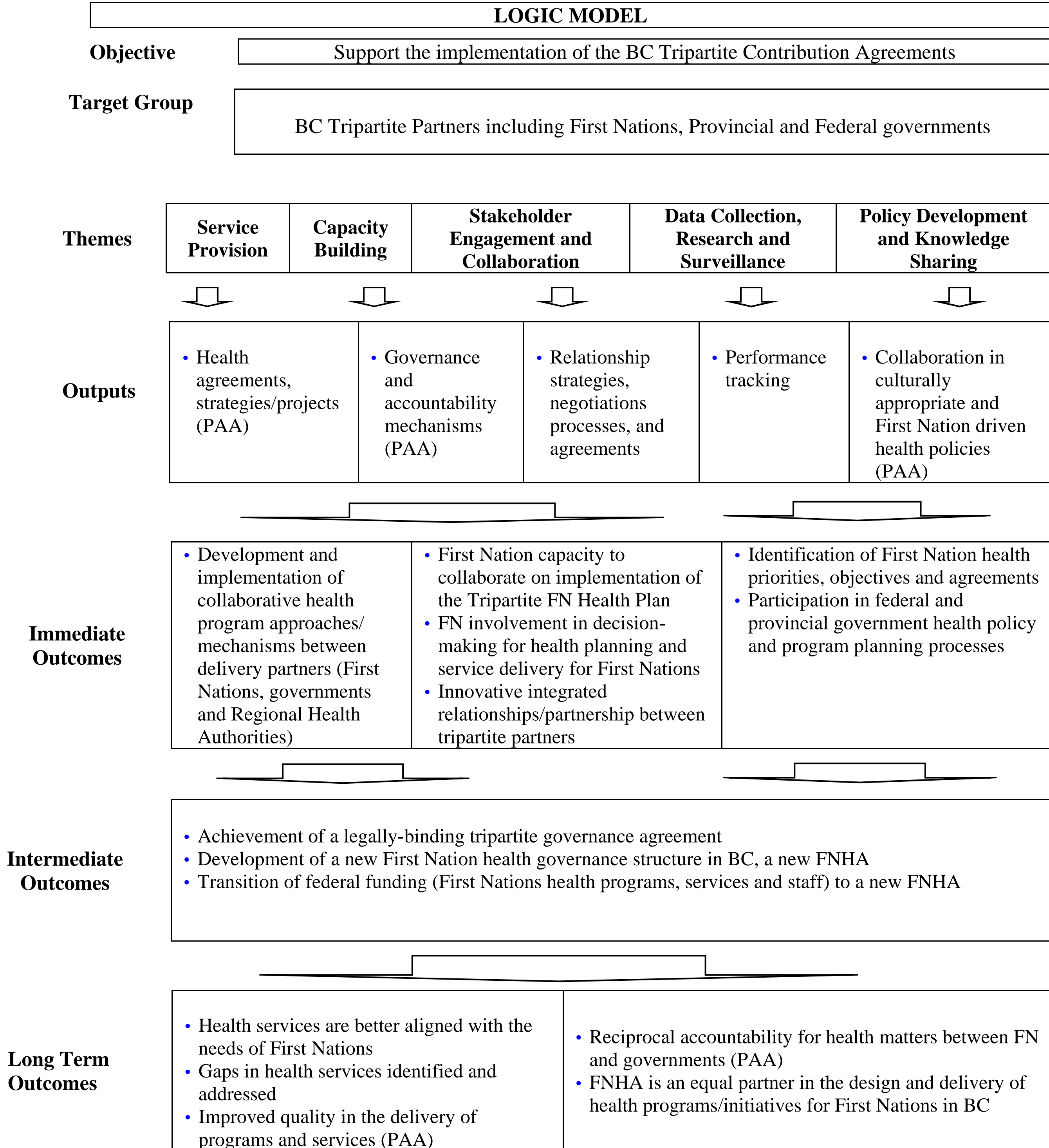
Over the long-term, Health Canada's policy approach is to achieve closer integration among federal and provincial health services provided to First Nations, as well as to improve access to these health services, reduce instances of service overlap and duplication, and increase efficiency where possible. Current contribution agreements support this approach, including the recently renewed Health System Integration Fund (Budget 2010), and the tripartite process in BC. These strategic policy approaches are reflected throughout FNIHB's Program Alignment Architecture (PAA) and its Strategic Plan, as a key objective of the Branch (see Section 2.2).

Logic Model

No previous logic model or relevant performance indicators existed for the BC Tripartite contributions. The contribution funding was captured within FNIHB's health planning program area, as a "Funding Model" or initiative, rather than a program.

In preparation for the request by the Treasury Board Secretariat in late 2011 to conduct an evaluation, a logic model was developed in consultation with key Health Canada employees from both the National Capital Region (NCR) and the BC regional office. This logic model indicated the expected outputs and outcomes from the BC Tripartite contributions.

Figure 1: First Nations BC Tripartite Contributions Logic Model



2.2. Program Authority and Resources

The Health Canada contribution funds allocated to the BC FNHA for the tripartite initiative are the only funds included in this evaluation, and they are illustrated in Figure 3 below.

The BC Tripartite Initiative contribution agreement funding began in 2007-08. As a result of changes to the PAA at that time, funding has been provided to the BC FNHA within two sub-program areas. These include:

- Funding for the initial $29M and subsequent $10M amendment for the Tripartite First Nations Health Plan is captured in: Health Planning & Management and Health Consultation & Liaison (as well as Health Systems Integration from the 2011 Authorities; and
- Funding for the $17M implementation funding is captured in: Health Research & Engagement and Health Planning and Quality Management components from the new authorities.

The expected outputs and/or outcomes for both sets of PAA performance measures for the sub-program areas noted above have been imbedded in the logic model (indicated by ‘PAA’) and remain consistent despite the changes within the PAA structure.

Table 2: Health Canada Contribution Funding

<table>
<tr><th>Fiscal Year</th><th>2007-08</th><th>2008-09</th><th>2009-10</th><th>2010-11</th><th>2011-12</th><th>2012-13</th><th>Total</th></tr>
<tr><td>BC First Nations Health Society*</td><td colspan="4">$29M</td><td colspan="2">$10M (amendment)
$17M</td><td>$56M</td></tr>
</table>

3. EVALUATION DESCRIPTION

3.1. Evaluation Scope

The focus of the evaluation has been carefully crafted to ensure the assessment of the BC Tripartite contribution agreements reflects the Health Canada funding to the recipient and its progress in transitioning toward the assumption of program design, management, and delivery. As such, there is a primary focus on the implementation of the contribution agreements (activities and outputs) as well as on the achievement of immediate and intermediate outcomes. The degree to which long term outcomes have been achieved is not included in this evaluation as they reflect a timeframe beyond the scope of the contribution agreements.

This evaluation covered the core issues as outlined below in the GoC Policy on Evaluation (2009) and included an assessment of the BC Tripartite contributions agreements' relevance and performance, including economy and efficiency. The evaluation covered the contribution agreements from 2007-08 to 2011-12.

Table 3: Evaluation Core Issues

Evaluation Core Issues and Questions		
Relevance		
Issue #1:	Continued Need for the Program	What is the need for the BC Tripartite contribution agreements?
Issue #2:	Alignment with Government Priorities	Do the BC Tripartite contribution agreements align with Government of Canada priorities?
Issue #3:	Alignment with Federal Roles and Responsibilities	Are the BC Tripartite contribution agreements aligned with federal roles and responsibilities?
Performance (effectiveness, efficiency and economy)		
Issue #4:	Achievement of Expected Outcomes	To what extent have the immediate outcomes been achieved? To what extent have the intermediate outcomes been achieved?
Issue #5:	Demonstration of Efficiency and Economy	Have the BC Tripartite contribution agreements been efficiently and economically implemented?

Departmental Assessment of Evaluation Risk
An evaluation risk assessment was conducted to determine an evaluation approach and the level of effort required to complete the evaluation. The overall risk ranking level for this evaluation, as determined in the Health Canada DEP 2011-12, was "medium".

Medium risk evaluations are subject to a 'reduced design' evaluation using at least two lines of evidence and a moderate sample size (e.g., moderate/targeted literature and document/data review, medium number of interviews). This was incorporated into the design of the evaluation.

3.2. Evaluation Approach

The evaluation included a participatory approach, that is, the inclusion of internal (NCR and Regional staff) stakeholders in the development of the evaluation framework, the evaluation conduct and review of the technical data as well as analysis of the evaluation report.

3.3. Evaluation Design

This evaluation used a non-experimental, results-driven descriptive design. The evaluation assessed the progress of the achievement of the expected results for the contributions made to the BC FNHA and included a focused analysis of resource allocation and utilization.

3.4. Data Collection Methods

An Evaluation Framework was developed to guide the evaluation. A data collection matrix was developed as part of this evaluation framework to guide the data collection strategy.

The methods used in this evaluation to collect data included (further details are provided in Appendix A):

- Document and literature review (reference provided in Appendix B); and
- Key informant interviews (N=23) with internal and external stakeholders.

Evidence was gathered from the different lines of inquiry and analyzed through the methods described below to allow for data comparison and to support evidence-based conclusions.

3.5. Data Analysis Methods

The data collected was analyzed using the following methods:

- Systematic review of data extracted from the documents, summary tables created, and conclusions drawn based on the summary data;
- Statistical analysis of quantitative data and appropriate charts created;
- Trend analysis (financial), a method of time series data analysis (information collected in sequence over a period of time), which compared data for the same indicator, to determine whether a relationship existed between the variables pertaining to that specific indicator;
- Qualitative data from key informant interview questions analyzed using a thematic analysis technique, where responses were systematically reviewed and emergent themes were identified and categorized; and
- Comparison of data from document reviews and stakeholder surveys to synthesize data from disparate sources, and validate trends as part of the findings of this assessment.

3.6. Limitations for the Conduct of the Evaluation and Mitigation Strategies

Most evaluations face constraints that may have implications on the validity and reliability of evaluation findings and conclusions. This section illustrates the limitations in the design and methods for this particular evaluation. Also noted are the mitigation strategies put in place to ensure that the evaluation findings can be used with confidence to guide program planning and decision making.

Table 4: Limitations

Limitation	Challenge	Mitigation Strategy
Performance Data Absence of a pre-existing performance measurement framework Limited availability of departmental financial data	The lack of ongoing performance measurement data to support the evaluation Lack of financial object costing data does not allow for a full assessment of economy and efficiency	Departmental staff, including regional FNIHB representatives designed a performance measurement framework in advance of the conduct of the evaluation to assist in identifying and collecting appropriate performance information through three lines of evidence A focused assessment of resource allocation and utilization was included in the evaluation along with a literature review to support the theoretical approach of capacity development as both effective and efficient
Key Informant Interviews Interviews retrospective in nature Sample size small but purposeful Selected interviewees were not part of the initiative early on	Interviews retrospective in nature, providing recent perspective on past events; can impact validity of assessing activities or results relating to improvements in the initiative Given the small sample size, community level perspectives were not included Some external interviewees had limited capacity to speak to the early development stages	Document review provides corporate knowledge An equal sample of external and internal-to-government interviewees were selected to provide a balanced perspective with FNHA leader identified as representing the community level perspectives Interview questions were adjusted to ensure that, across interviews, all stages of the initiative were covered

4. Key Findings

4.1. Relevance

4.1.1. Core Issue #1: Need for the BC Tripartite Contribution Agreements

There was a relevant need to support the BC Tripartite Initiative with contribution funding in order to enable BC First Nation engagement in the BC tripartite initiative and involvement in designing, planning and implementing BC First Nations health service delivery.

Federal contribution agreements provided support to BC First Nations to build organizational infrastructure which would enable them to "[enhance] their capacity to design, manage, deliver and evaluate quality health programs and services". Health Canada's 2012-13 Report on Plans and Priorities (RPP) stated that funds flowing from the contribution agreements are used for purposes such as "planning and management for the delivery of quality health services" and to "integrate and realign the governance of existing health services".[4]

In their 2007-10 progress report, the First Nations Health Council stated: "Of all the strategies and objectives within our plan, securing funding certainty is probably the most critical objective for the First Nation Health Society… Our ability to plan for investments for implementing the BC *Tripartite First Nations Health Plan* (TFNHP) and assign our financial and human resources is better now that First Nations have a more secure picture of the revenues supporting the TFNHP implementation."[5]

The groundwork was laid for the first BC Tripartite contribution agreement following the signing of the 2007 *Tripartite First Nations Health Plan*. Health Canada committed to provide $29M over four years (2007-08 to 2010-11) "to support BC First Nations in completing the 29 action items identified in the three-party Health Plan".[6] The 2007-08 Health Funding contribution agreement indicated, "[For] the purposes of this agreement, the focus is on the governance of health programs and services".[7]

In 2010, upon reaching an agreement-in-principle (i.e., *Basis for a Framework Agreement on Health Governance*), Health Canada committed an additional $10M of internal funds over two fiscal years (2011-12 and 2012-13), to the recipient. This funding was amended to the $29M contribution already provided in 2007-08 to support the continued work on the 29 Health Action items and the additional 10 Health Action items added later, as well as the ongoing tripartite governance discussions.

The need for the new FNHA was articulated, in the tripartite document "Implementing the Vision"[8] which stated that the Tripartite First Nations Health Plan signed by the First Nations Leadership Council (FNLC), the Government of Canada and the Government of BC on June 11, 2007 committed the parties to put in place a new structure of governance that "leads to improved accountability and control of First Nations health services by First Nations." As this work continued, Health Canada signed the *BC Tripartite Framework Agreement on First Nation Health Governance* (2011) and, through a contribution agreement, provided $17M as the federal contribution toward the implementation and transition costs for BC First Nations to implement the *Framework Agreement*. In part, this allowed movement toward the evolution of the First Nations Health Society into the new First Nations Health Authority (FNHA[9]).

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4 Health Canada Report on Plans and Priorities, 2012-2013, p. 37-38
5 First Nations Health Council, 3 Years of Progress 2007-2010, p. 97
6 Health Canada, BC Tripartite Initiative Health Canada Transition Plan, January 2012
7 Health Funding Consolidated Contribution Agreement (2008-02-101-00010), p. 1
8 Implementing the Vision-Governance of First Nations Health Services in British Columbia: http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/vision-eng.pdf
9 Implementing the Visi8on – Governance of First Nations Health Services in British Columbia: www.hc-sc.gc.ca/finiah-spnia/alt_formats/pdf/pubs/services/tripartite/vision-eng.pdf

When the final transition to the FNHA is completed, the *Framework Agreement* commits the department to "shift away from its delivery role, and focus its work on funding, accountability, and acting as a governance partner".[10]

4.1.2. Core Issue #2: Alignment with Government Priorities

The BC Tripartite contribution agreements were aligned with federal government and Health Canada priorities.

The document review found some evidence that the BC Tripartite contribution agreements are publically supported by the federal government. There were no specific references in any Speeches from the Throne (SFT) or budget speeches in Parliament. However, there were specific political commitments from the federal Minister of Health when the Minister signed key documents with BC First Nations and the Province of BC. In particular, the Minister signed the *Tripartite First Nations Health Plan* in 2007-08, committing to health actions and governance discussions. This included the initial $29M contribution agreement.

In Budget 2008, FNIHB received funding for tripartite negotiations[11]. The Budget 2008 document (speech) refers to this funding combined with other FNHIB funding.

The document review found that BC Tripartite contribution agreements aligned with the strategic outcomes of Health Canada, and with the mandate and objectives of the FNIHB.

In terms of Health Canada's strategic outcomes, the BC Tripartite contribution agreements aligned most closely to Strategic Outcome 3: "Health Canada plays an important role in supporting the delivery of, and access to, health programs and services for First Nations and Inuit" and will "continue collaborative efforts with provinces / territories and First Nations and Inuit to ensure quality service delivery, and implement the British Columbia Tripartite Framework Agreement on First Nations Health Governance".[12]

Health Canada's *First Nations and Inuit Health Strategic Plan (April 2012)* stated: "How First Nations and Inuit health services are organized, and how they interact with the broader health system, are fundamental considerations for equitable access to healthcare services; and these are also areas in which Health Canada has a particular mandate to promote progress."[13]

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[10] Health Canada, BC Tripartite Initiative Health Canada Transition Plan, January 2012 ., p. 13
[11] $17M over 5 years, although none was provided that year to the FNHA.
[12] Health Canada, BC Tripartite Initiative Health Canada Transition Plan, January 2012, (2012-02-101-00023, p. 6
[13] Ibid , p. 7

Health Canada's 2010-2011 Departmental Performance Report (DPR), stressed the department's continued and important role in supporting the delivery of, and access to, health programs and services for First Nations and Inuit; and in building departmental strategies "to help further reduce the gap between health outcomes of First Nations and Inuit and those of other Canadians", a key goal of the TFNHP. A commitment to continue to explore the "potential to integrate and harmonize federal and provincial First Nations health programs and services through tripartite discussions" was expressed as a Departmental priority.[14]

In a review of the past four years of Health Canada's RPP, the department expressed its ongoing commitment to develop capacity to support delivery of health services by First Nations and Inuit communities. In the most recent RPP (2012-2013), the Minister committed to implementing the *British Columbia Tripartite Framework Agreement on First Nations Health Governance,* and promised to "strengthen collaboration with provinces, territories, and with First Nations and Inuit communities to ensure quality service delivery".[15]

The document review also found that the BC Tripartite contribution agreements aligned with the FNIHB mandate and objectives to support the health needs of First Nations by: "ensuring availability of, and access to, quality health services; supporting greater control of the health system by First Nations and Inuit; and, supporting the improvement of First Nations health programs and services through improved integration, harmonization, and alignment with provincial/territorial health systems. Alignment with departmental strategic priorities/outcomes is further corroborated by the establishment of the new BC Tripartite Initiative office at headquarters "to lead the finalization and roll-out of the Framework Agreement."[16]

4.1.3. Core Issue #3: Alignment with Federal Roles and Responsibilities

The BC Tripartite contribution agreements were aligned with federal government and Health Canada roles and responsibilities to support and strengthen First Nations participation in policy and planning for the delivery of health services.

The federal government's role is to support initiatives that strengthen First Nations and Inuit health. This is accomplished in part through providing funding through contributions. A review of RPPs over the past five years indicated that BC Tripartite contribution agreements are consistently aligned with departmental program activities. From 2007-08 through to 2012-2013, Health Canada referred to its role as "supporting the delivery of, and access to, health programs and services for First Nations and Inuit".

In 2011, Strategic Outcome 3 (revised) was reframed to include efforts to strengthen First Nations health programming by increasing First Nations and Inuit control of health program delivery, as well as integration of First Nations and Inuit programming with existing provincial health systems and programming to leverage efficiencies and avoid duplication. In describing the Strategic Outcome, Health Canada's First Nations and Inuit Health Strategic Plan stated, "Health Canada supports First Nations and Inuit in achieving their health and wellness goals, by

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[14] Health Canada, Departmental Performance Report, 2010 – 2011, p. 10
[15] Health Canada, 2012-2013, Report on Plans and Priorities, p. 1
[16] Health Canada, BC Tripartite Initiative Health Canada Transition Plan, January 2012, p. 11

working with First Nations, Inuit, provinces and territories to advance collaborative models of health and health care that support individuals, families and communities from a holistic perspective, while respecting jurisdictional roles and responsibilities."[17]

The Planning Highlights of Health Canada's 2012-2013 RPP identified the department's long-term vision for the integration of federal and provincial health services for First Nations and Inuit, and committed to "continue to work with the government of British Columbia and British Columbia First Nations to implement a Tripartite Framework Agreement on Health governance - a historic first for First Nations health".[18]

Contribution agreements are governed by specific terms and conditions which can be set to help achieve departmental objectives. Health Canada's Terms and Conditions for FNIHB's Health Infrastructure Support Authority states:

- The Health Infrastructure Support Activity underpins the long-term vision of an integrated health system with greater First Nations and Inuit control by enhancing their capacity to design, manage, deliver and evaluate quality health programs and services. It provides the foundation to support the delivery of programs and services in First Nations communities and for individuals, and promotes innovation and partnerships in health care delivery to better meet the unique health needs of First Nations and Inuit.
- Improving the health of Aboriginal people is a shared responsibility between federal, provincial/territorial and Aboriginal partners. To improve health systems to better meet the needs of First Nations and Inuit, FNIHB works with its partners to develop sustainable, long-term, integrated solutions, through dedicated and collaborative efforts, including developing partnerships between provincial governments and First Nations to integrate federal and provincial health systems.
- FNIHB also supports the improved capacity of First Nations and Inuit communities to address their own unique health needs by increasing their control over health program design and delivery.

Evidence to demonstrate the legitimacy of the Federal role in the contribution agreements was found in various documents including the following policies and plans:

- The *Indian Health Policy*, 1979: "Policy for federal programs for Indian people, (of which the health policy is an aspect), flow from constitutional and statutory provisions, treaties and customary practice…The Federal Government recognizes its legal and traditional responsibilities to Indians".
- The *Policy* outlined three pillars upon which an increasing level of health in Indian communities must be built: "The second pillar is the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations."[19]

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[17] Health Canada's First nations and Inuit Health Strategic Plan, Proposed Outline of Core Content (2012-020111-00078), p. 1
[18] Health Canada, 2012-2013, Report on Plans and Priorities (#109-2012-2013), p. 43
[19] Indian Health Policy 1979 (2008-02-110-00069), p. 1

- The *Indian Health Transfer Policy* (1989): This policy's goal is to encourage uptake of community-based health care services. It has provided opportunities for some communities and Tribal Councils to take more responsibility in planning and delivering health services and programs.[20]
- The outline to *Health Canada's First Nations and Inuit Health Strategic Plan* (April 2012) referred to the Strategic Objective (approved by the federal government in 2011) which identified the department's role to support First Nations and Inuit "in achieving their health and wellness goals, by working with First Nations, Inuit, provinces and territories to advance collaborative models of health and health care that support individuals, families and communities from a holistic perspective, while respecting jurisdictional roles and responsibilities."[21]
- Furthermore, "How First Nations and Inuit health services are organized, and how they interact with the broader health system, are fundamental considerations for equitable access to healthcare services; and these are also areas in which Health Canada has a particular mandate to promote progress. For these reasons, ensuring access to quality health services is a key strategic goal for the Branch."[22]
- The *Transformative Change Accord: First Nations Health Plan* (TCA: FNHP) (2006) referred to the federal government's jurisdictional role. The TCA:FNHP acknowledged the "established and evolving jurisdictional and fiduciary relationships and responsibilities" and noted the importance of the partnership with the federal government as "fundamental to the success of the Plan".[23]
- The TCA:FNHP also noted the historical nature of federal government funding, through the First Nations and Inuit Health Branch, for a range of health programs to support First Nations people (on reserve). Through these funding 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." The TCA:FNHP argued, "It is this network and these community-based solutions that must be developed and supported."[24]

These documents indicated a trend toward increasing the control/authority of First Nations communities in governance and health services, and tended to recognize the relative disadvantages of First Nations and Inuit communities when it comes to health status.

These trends are reflected in the BC Tripartite contribution agreements, which support the improvement of the health status of these communities, and increase the capacity of BC First Nations communities to design, manage and deliver health programs and services.

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[20] Indian Health Transfer Policy, 1989 (#110) (retrieved from: http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/10_years_ans_trans/index-eng.php)

[21] Health Canada's First Nations and Inuit Health Strategic Pl.an, Proposed Outline of Core Content, April 2012, (2013-02-111-00078), p. 1

[22] Ibid., p. 4

[23] Transformative Change Accord: First Nations Health Plan (TCA:FNHP) – Supporting the Health and Wellness of First Nations in British Columbia (2007-04-111-00054), p. 2-4

[24] Transformative Change Accord: First Nations Health Plan (TCA:FNHP) – Supporting the Health and Wellness of First Nations in British Columbia (2007-04-111-00054), p. 4

4.2. Performance

4.2.1. Core Issue #4: Achievement of Immediate Outcomes

Immediate Outcome 1: **Development and implementation of collaborative program approaches and mechanisms between delivery partners (First Nations, governments and Regional Health Authorities)**

The evaluation found that collaborative health program approaches and mechanisms between delivery partners (First Nations and federal and provincial governments, including provincial Regional Health Authorities) have been established.

The development and implementation of collaborative health program approaches and mechanisms has evolved over time and is demonstrated in two key initiatives:

1. The Tripartite First Nations Health Plan (TFNHP); and
2. The BC Tripartite Framework Agreement on First Nation Health Governance, or *Framework Agreement*.

The TFNHP (approved May 2007) set forth a "collective vision" that "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".[25] As one of the components of the governance, relationships and accountability structure, the Parties committed to the establishment of a First Nations Health Advisory Committee to "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".[26]

The TFNHP[27] set out an agreed vision for governance reform that would result in health service delivery that reflects the needs of First Nations. It identified four components:

- A First Nations Health Governing Body (which is now being called a First Nations Health Authority-FNHA) that would enact policies, identify results, allocate resources, establish service standards and implement ongoing reciprocal accountability measures;
- A First Nations Health Council that would serve as an advocacy voice for First Nations, participate in federal and provincial policy and planning processes, and provide leadership to implement the Plan;
- A Tripartite First Nations Health Advisory Committee (now called the Provincial Advisory Committee on First Nations Health) to monitor health outcomes and the Aboriginal Health Plans of Regional Health Authorities and to recommend actions to the Parties; and,

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25 Tripartite First Nations Health Plan (2008-04-101-00057), p. 2

26 Ibid, p. 4

27 Implementing the Vision-Governance of First Nations Health Services in British Columbia: http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/pdf/pubs/services/tripartite/vision-eng.pdf

- A First Nations Health Directors Association composed of First Nations Health Directors and other health professionals to focus on capacity building, training, knowledge transfer and professional input and support for First Nations health programs within BC.

The *Framework Agreement* (FA) reiterated the need for the partners to "work together in a collaborative manner" to build a new Health Governance Structure "in which First Nations will plan, design, manage and deliver certain health programs and services" and build "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 First Nation Health Programs".[28]

The FA further committed the tripartite partners 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",[29] and the FNHA, more specifically, to establishing "collaboration and integration" with the governments and other health and health-related organizations.[30]

The document review found other examples of collaborative approaches established by BC First Nations including:

- A multi-jurisdictional planning framework that provided service delivery linkages between First Nation Community Health Plans and Regional Health Authority plans. [This requirement is identified in the TFNHP and the FA which indicates the requirement for BC Regional Health Authorities to develop local health plans for all BC First Nations, recognizing "the fundamental importance of community solutions and approaches"[31]]. The First Nations Health Council process involves meetings of First Nations in each of BC's five health regions. First Nations Regional Health Caucuses (Fraser; North; Vancouver; Vancouver Island; Interior) were established as "vehicles" to come together at regular intervals, work with and invite partners to the table. The regional tables were established to serve as the "arms and legs" of the regional caucuses and to negotiate agreements with the Regional Health Authorities.
- The Consensus Paper: *British Columbia First Nations Perspectives on a New Health Governance Arrangement,* was developed by the FNHC based on the feedback from five regional caucuses and Health Partnership Workbooks and articulates province-wide principles and advice for First Nations health governance. This paper brings together the common elements from the five Regional Caucuses, and provides direction to the First Nations Health Council to move forward and work with BC and Canada to conclude a new First Nations Health governance structure.
- The TFNHP identified over 29 collaborative projects ("Health Actions"), and later added an additional 10 projects, that aim to improve health outcomes, access to services and/or coordination of health delivery. As an example, the document review also found that

[28] BC Tripartite Framework Agreement on First Nation Health Governance, (2011-02-101-00001), p. 5
[29] Ibid, p. 17
[30] Ibid, p. 17
[31] Tripartite First Nations Health Plan, p. 1

federal, provincial and First Nation partners of the TFNHP collectively developed a Project Charter for the First Nations Tele-health Expansion Project. Within the framework of this initiative, the First Nation, federal and provincial partners collaborate to build capacity in First Nation communities and begin the process of application development for the enhancement and integration of service priorities targeted in the TFNHP.

- The hiring of an Aboriginal Physician Advisor within the Provincial Ministry of Health. The 2007 appointment of the Aboriginal Physician Advisor demonstrated that First Nations communities were becoming more involved in discussions and planning about their own health care priorities and challenges. In 2012, the Advisor was appointed as Deputy Provincial Health Officer within the BC Ministry of Health in April 2012, consistent with a commitment made in the Tripartite Framework Agreement.

Information garnered from key informants for this section is included under *Immediate Outcome 6: Participation in federal and provincial government health policy and contribution agreements planning processes.*

Immediate Outcome 2: First Nation capacity to collaborate on implementation of the Tripartite First Nations Health Plan

The evaluation found that First Nation capacity to collaborate on the implementation of the Tripartite First Nations Health Plan has increased over the course of the contribution agreements.

The document review found that significant effort has been directed toward implementation of the Tripartite First Nations Health Plan including the following:

- The First Nations Health Society supports the implementation of the TFNHP by working with the First Nations Health Council, First Nation communities and the tripartite partners - 13 meetings were held in 2009-10;[32]
- Five First Nations Health Caucuses (Fraser; North; Vancouver; Vancouver Island; Interior) were established in BC First Nations as "vehicles" which came together at regular intervals, worked with and invited partners to the table;
- A roster of First Nation health professionals and advisors were retained by FNHA to carry out the implementation of the Health Actions in the Plan;[33]
- Through the establishment of Community Engagement Hubs (CeH), First Nations were able to communicate, collaborate, and plan with neighboring communities. CeH represent most of BC's 203 First Nations; as of March 2010 there were 25 Hubs established across the five regions. [In 2007 – 2008, 10 community engagement hubs were established involving 100 First Nations communities; 2008 – 2009 nine CeH were added; and by March 31, 2010, 25 hubs represented some 160 communities (79% of 203)];

32 First Nations Health Council Report, (2011-01-03-00085)
33 Ibid.

- The FNHA supplemented the CeHs with the appointment of Community Engagement Liaison positions in the Interior, Vancouver Island and Northern regions to support communities, create opportunities for dialogue and exchange and strengthen communications between the technical team, the hub members including provincial regional health authorities in each region (2007-10);
- The First Nations Health Directors Association provided a mechanism for community health directors and community-based First Nations health organizations to participate in the design and planning of services in their areas;
- A number of mechanisms/tools/guidance materials were implemented to help build First Nation capacity by providing support, advice, access to current information, ways to build linkages and enable communities to engage, such as the following: FNHC website, quarterly newsletters/quarterly info bulletins published in April, July, October and January of each year, email "blasts" of new or emerging issues or information, the five all-chiefs assemblies, "Gathering Wisdom" forums and the use of a FNHC Youth channel to help reach the younger audiences. With the help of these vehicles, First Nation capacity continues to grow and evolve. Many of these tools have supported the FNHA in bringing together First Nation communities and indirectly supporting the TFNHP in the longer term; and

The questions in key informant interviews used to determine First Nation capacity were related to: leadership, planning and risk management, financial management, human resource management, membership, external relations, information management and technology as well as basic administration. These findings are summarized below:

Leadership

Most (n=17) believed that the leadership function of First Nation health governance structures in BC has evolved significantly over the evaluation time period. Evidence cited to support this claim includes:

- The clear separation of politics and operations;
- The ability of First Nation leadership to cultivate trust and consensus;
- Political appointments on the health council have been replaced with nation based representation;
- Well considered, fluid decision making processes;
- A strong, well communicated, clear vision;
- The promotion of collaboration;
- The support of the Chief Executive Officers (CEOs) of all BC provincial RHAs;
- The creation of the health directors' association; and
- The quality of applicants and rising interest in working for the FNHA.

Some (n=4) noted that the comparison is unfair because although FNHA existed in 2008, it had a very different mandate and function than the current FNHA. Some (n=4) indicated that the current FNHA is unrecognizable from the earlier entity that existed when the tripartite process first started. A few (n=3) believed that there was always effective First Nation leadership in health even if the formalized structure was not particularly developed.

The interviews indicated that the current FNHA has knowledgeable, high profile board members and strong, capable people assuming leadership roles elsewhere in the organization.

Membership

This particular item in the interview schedule caused much confusion because it applied more to *government* than to *governance,* so respondents were directed to consider either board membership or client populations. Early in the tripartite process, many respondents (n=12) felt that this function was largely underdeveloped and somewhat unrepresentative but that it has progressed substantially over time to be well developed, operational and successful.

Board membership has changed from political appointments of individuals who may or may not have the appropriate skills to a much more sophisticated, merit based system where successful candidates have skills in health administration and their obligations to their client base are clear. Still challenges remain with respect to the client base.

Planning and Risk Management

Many (n=11) felt that the FNHA's planning and risk management function was underdeveloped in the early phases. However, a few (n=3) cited the TFNHFP as evidence of early development. Much of the early tripartite work had been focused on governance so the FNHA's overall planning and risk management had not been a priority until the implementation of the second contribution agreement.

The majority (n=15) believed that development is clearly in progress with respect to planning and risk management with a few (n=3) who felt that this capacity has changed dramatically. Respondents cited the sophisticated process of setting direction, the development of good planning products as well as the clearly articulated conditions of tripartite relationships as evidence of First Nation capacity. However, the majority (n=15) concurred that challenges remain with respect to the rapid expanse and scope of the organization once transfer is complete.

There are content specific, expert led tripartite strategy councils focused on the finer details of planning but they vary in their stages of development. Each party in the triad comes with different mandates, objectives and goals so improved, *unified* strategic planning may be beneficial. Program performance reporting is now integrated but joint planning is needed with BC's RHAs.

The FNHA could benefit from clearer planning regarding how operations could be more focused on the social determinants of health. But, the scope of the FNHA has expanded and will continue to do so. Although successful at maintaining a small bureaucracy, the FNHA will soon manage a large workforce and it will need to evolve its infrastructure and practices accordingly.

Financial Management

Many (n=8) respondents didn't know the state of financial management early on and for those that did, it felt much like comparing apples to oranges because in the early years the financial relationship was simpler and involved two parties, not three.

Of those who chose to answer the question about financial management, the majority (n=15) believed that development is clearly in progress as evidenced by the fact that the FNHA has had clean audits with only minor concerns and there has never been the need for co-management or third party management. Some (n=4) felt that this progress is mature and that the FNHA is well developed, operational and successful in this regard. There has been movement from paper-based transactions to an electronic transfer system, as well as the development of an established, qualified, competent financial management team.

The Request for Proposal (RFP) process is open and transparent with all solicitations posted on the web, but the FNHA has doubled in size and, with this growth, systems changes are required. The FNHA will go from managing a smaller annual budget to $400 million annually and there remains a reputational risk in the minds of a few respondents.

Human Resources Management

The majority of respondents (n=15) believed that human resource management was underdeveloped in the early phases of the tripartite process. There is an even divide between those (n=11) who felt that development is clearly in progress and those (n=11) who felt that it remains underdeveloped. Respondents who saw development in progress cited:

- Almost exclusive focus upon human resources issues and significant progress in a rapidly growing organization;
- Retention of seasoned human resource professionals in their teams and as consultants;
- Active orientation of new team members;
- Ability to secure new employees, fluidly and quickly; and
- Extensive work on their benefits package.

For respondents who expressed concern that this function remains underdeveloped, reasons included the rapid rate and quality of change.

Information Management and Information Technology

Early in the process, the majority (n=15) felt that information management and technology was underdeveloped. The majority (n=15) now feels that development is in progress with a few who believe that it is underdeveloped and a few others who believe it is well developed. Evidence of well-developed use of information management systems and technology included the use of cell phones to vote on issues at Gathering Wisdom Forums, the relevance and up to date content on their website, as well as their work with the University of British Columbia's House of Learning. But, there is commonly accepted sentiment that there is much work ahead.

External Relations

For those who felt in a position to comment on the state of external relations early in the process, there was a roughly even distribution between those who felt it was underdeveloped and those who believed that development was clearly in progress, with a few who felt that this function was already well developed. The majority (n=14) believe that this function is well developed with a few identifying it as operational and successful and many others stating that development was clear. Respondents cited the following evidence to support their claims:

- There have been relationships established with the American Indian Health Service in both Alaska and Hawaii;
- There is increased contact with the Ministry of Health in BC as well as with RHAs;
- The BC Medical Association has been approached and is supportive;
- The Chief Executive Officer has published a paper about this transition as a way of sharing and garnering interest in the tripartite process;
- Universities and the research community know about and are supportive of the tripartite process;
- Relationships are developing with professional associations, hospital boards and health employees associations; and,
- There is widespread attention from other First Nations some of whom have models of excellence to share (e.g., Big Stone's operation of NIHB).

The FNHA recognizes the need to be an 'open' organization that seeks partnerships and linkages beyond First Nation communities, BC or even in Canada. They have strengthened existing relationships and are quite willing to work with external entities as well as operate joint initiatives.

Still, more development may be needed to expand linkages with a broader variety of professional associations, and formal relationships with supportive partners still need to be established. In addition, there remains a consideration of how First Nations off-reserve can contribute.

A few respondents (n=3) felt that greater transparency is needed within the tripartite relationship. In particular, it was recommended that the strategic vision be more actively shared to enable more collaboration and generate positive excitement for the changes ahead.

Basic Administration

In the early years, many (n=9) felt that either basic administration was under-developed or development was clearly in progress. But, most respondents felt that they lacked sufficient information to comment on this question. Of those who felt comfortable responding, most (n=17) believed that development was clearly in progress and remarked that there has been rapid growth with corresponding adjustments, unqualified audits without management letters, and team continuity. A few felt that basic administration was well developed or operational/successful.

Immediate Outcome 3: First Nation involvement in decision-making for health planning and service delivery.

The evaluation found evidence that demonstrates BC First Nations have increased their ability to engage in the decision-making process for health planning and service delivery.

The Health Actions arising from the *Tripartite First Nations Health Plan* exemplified BC First Nations engagement in health planning and service delivery, which included working with the province and First Nations community service providers in the areas of Governance,

Relationships & Accountability, Health Promotion/Injury & Disease Prevention, Health Services and Performance Tracking.[34] There were a number of different ways in which First Nation communities and individuals participated in health planning, including:

- The BC First Nations Health Council (FNHC) provides a forum for appointees selected by each of the three political bodies (First Nations Summit, Union of BC Chiefs and BC Assembly of First Nations) to focus on delivery of the TCA: FNHP and the TFNHP. The FNHC was established specifically to address Action #1 in the TCA: FNHP (Governance: Establish a new FNHC) to provide leadership for the TCA: FNHP, and eventually the TFNHP.
- Gathering Wisdom Forums (5 held to date) engaged all BC Chiefs and their proxies, created opportunities for shared dialogue, and provided direction. Direction obtained from the Forums specifically informed and approved the development of the Tripartite First Nations Health Plan, and supplemented actions and agreements from the TCA: FNHP.
- The *FNHA* Policy Team assembled seven position papers which brought together all of the First Nation feedback, input, ideas and issues raised over the past 3 years through Regional Caucuses. Analyses provided a focus for the specific areas that concern First Nations in BC and the changes needed to the respective Federal and Provincial systems to make services more responsive to First Nations' needs.
- Regional Caucuses, Regional Tables and Community Engagement Hubs, where the regions themselves develop their own regional caucuses, established regional tables to serve as the "arms and legs" of the regional caucuses, and negotiated agreements with the Regional Health Authorities to incorporate First Nations decision-making into the provincial health system. Four out of five current 'accords' have been finalized between FNHA and the RHAs to integrate services [note: since the completion of the evaluation, all five 'accords' have been finalized].

From the document review, it was noted that a model of community-driven and nation-based decision-making has been adopted. This model has been adopted by the FNHA[35] based on, and supported by, the First Nations Health Council policy of *"room for everyone"* (meaning all First Nations in BC have a place in the process) and efforts have been made to ensure that all of BC's 203 Chief Councilors and their advisors are well informed and encouraged to participate. Due to their conceptual similarity, and to avoid duplication and maximize clarity, the evidence from key informant interviews for the development of First Nation involvement in decision making for health planning and service delivery, and the identification of First Nation health priorities and objectives, are provided in *Immediate Outcome 5: Identification of First Nation health priorities, objectives/ agreements.*

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[34] Indicated in the First Nations Health Council, *A Year in Review 2007-2008* (2009-01-105-00050), p. 5-6)
[35] FNHS Annual Report (2010-2011), pg. 3

Immediate Outcome 4: Innovative integrated relationships between tripartite partners

The evaluation found that an innovative and integrated relationship and partnership between the tripartite partners had been established. Innovation or change of this magnitude presents challenges and opportunities, however, the steadfast partnership, commitment and shared vision of all players was crucial to ensuring the achievements made to date, the continued success of the developing FNHA, and to the tripartite initiative as a whole.

The *BC Tripartite First Nations Health, Basis for a Framework Agreement on Health Governance* (signed in 2010, preceding the final *Framework Agreement*) indicated: 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."[36]

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."[37]

The *Framework Agreement* (signed in 2011) legally committed the tripartite partners to establish innovative and integrated relationships. It stated: "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.[38]

The *Framework Agreement* indicated the acknowledgement of the tripartite partners "to work together to build": (1) a new Health Governance Structure; and (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)".[39]

The tripartite parties agreed to a tripartite governance structure in the *Framework Agreement*. As part of this structure, the three parties established a Tripartite Implementation Committee to provide "general oversight and coordination of the commitments of the Framework Agreement, including development of a tripartite implementation plan to identify targets and timelines".[40]

The *Framework Agreement* further described the new health governance structure, of which one element is a Tripartite Committee on First Nations Health (Tripartite Committee), co-chaired by the Deputy Minister of the BC Ministry of Health, the Assistant Deputy Minister of Health Canada/FNIHB, and the Chairperson of the board of the FNHA, and including members from the provincial Regional Health Authorities.

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[36] TFNHP, (2008-04-101-00057), p. 1
[37] Framework Agreement, (2011-02-101-00001), p. 6
[38] FNHS Annual Report (2010-2011, p. 4
[39] Ibid., p. 5
[40] BC Tripartite Initiative, Health Canada Transition Plan, January 2012 (2012-02-101-00023), p. 13

The key functions of the Tripartite Committee include: meeting twice per year; coordinating and aligning planning, programming, and service delivery between the FNHA, and the BC Regional Health Authorities and associated Aboriginal Health Plans; facilitating discussions and coordinating planning and programming among BC First Nations, British Columbia and Canada on all matters relating to First Nations health and wellness; providing a forum for discussion on the progress and implementation of the FA and other health arrangements; and preparing and making public an annual progress report on the progress of the integration and improvement of health services for First Nations in BC.

Key informant interviews explored innovative and integrated relationships between the parties and examined what supported collaboration.

Key informants (n=22) identified that for the tripartite process, including the work within the scope of the two contribution agreements, the following supports existed in building collaborative relationships between the parties:

- A formal tripartite agreement;
- High level political leaders (Premiers and Ministers) and advocates within each system;
- Ongoing dialogue between BC, Health Canada and First Nation parties that was sustained by funding;
- Committees established to complete the work;
- Key community players involvement/participation in the process (i.e., Chiefs);
- Pre-established working relationships between First Nations and BC;
- Unity amongst First Nation communities;
- The positive role that BC played in moving the Aboriginal health agenda forward before the tripartite process;
- Knowledge and skills of the negotiator; and
- Health expertise from Health Canada.

Key informants identified the following elements as part of the tripartite process, including the scope of work within the contribution agreements, as building collaborative relationships between the parties:

- Trust;
- Open, clear communication and listening skills;
- Patience;
- Ability to challenge the status quo, be open to change and willing to learn;
- Acknowledgement of each other's perspectives and priorities;
- Ability to plan and be able to act on those plans; as well as,
- Ability to make timely decisions and think critically.

Immediate Outcome 5: Identification of First Nation health priorities, objectives and/or agreements

The evaluation found that significant progress was made in identifying and prioritizing First Nation health priorities and objectives. Many agreements were signed that demonstrate progress towards a new BC First Nations Health Authority.

First Nation Health Priorities, Objectives

The document review found that the tripartite partners signed the Tripartite First Nations Health Plan (2007), in which 29 health actions were identified as priorities within four main 'streams': Governance, Relationships and Accountability; Health Promotion/Disease and Injury Prevention; Health Services; and Performance Tracking.

An additional 10 priority action items were added to the original 29 actions to be addressed in the tripartite relationship between the FNHA, and provincial and federal governments. In total, 8 actions related to "governance" and 31 actions related to "health actions". The 31 actions have been clustered into seven health action areas including: Primary Care & Public Health; Mental Health, Addictions and Suicide Prevention; Maternal and Child Health; Health Human Resources; e-Health; Health Planning; and Health Knowledge and Information.

Agreements

Health Canada committed to provide $29M over four years of internal funds (2007-08 to 2010-11) to support BC First Nations in engaging in the development and implementation the 29 action items identified in the Tripartite First Nations Health Plan.

Further support was provided after the three parties reached an agreement-in-principle (Basis for a Framework Agreement on Health Governance); Health Canada committed to provide an additional $10M of internal funds, over two fiscal years (2011-12 and 2012-13) to BC First Nations. This funding was amended to the $29M contribution already provided in 2007-08.

The document review found that the 2011 federal contribution of $17M was focused more specifically on the implementation and transition costs of the FNHA to establish itself as the new FNHA (including supporting its operations, and the eventual transition of programs, services and functions to its management).

This funding was a commitment of the Tripartite Framework Agreement, reflecting the mutual three-party objective to establish a new governance structure (as an extension of the TFNHP).

The key informant interviews were used to determine First Nation involvement in decision making and the identification of First Nation health priorities were related to community involvement and policy-making. The synthesis of responses is shared below.

Community Involvement

There is near unanimous (n=20) agreement that this function has both developed significantly and is operational, mature and successful.

There are extremely sophisticated regional caucuses that are linked to and closely parallel BC's RHAs. There are formal accords with four of five RHA's as well as a new health directors association. Engaging communities, which are very diverse and sometimes situated in tough geographical environments, was largely successful.

Together with Gathering Wisdom, community consultation efforts yielded 80-90 percent support on resolutions. Communication through various media (e.g., electronic, print, in person) continues; however, a few felt that more development may be needed.

Policy Making

In the early days of the tripartite process, most (n=11) felt that the policy making function was underdeveloped. Many felt that although development is clearly in progress, much work remains. Although a suite of policies exists and there has been evolution in the policy process, the organization is still in the developmental stages and, once transfer is complete, much more policy redesign will be possible.

The development of human resource policies is the current focus; however, all areas of operation will require policies. As the responsibility increases, so too will the need for clear policy.

Immediate Outcome 6: First Nation participation in federal and provincial government health policy and planning processes

The evaluation found that, although there was significant evidence demonstrating the establishment of mechanisms for First Nations participation in the health policy and planning processes of the federal and provincial governments, there is still much work to be done, particularly in the areas of integrated service delivery.

The document review found a number of examples of health policy and planning progress including:

- The *Tripartite First Nations Health Plan* (signed by the First Nations Leadership Council, Canada, and BC on June 11, 2007);
- In 2010, a tripartite agreement-in-principle (*BC Tripartite First Nation Health*; *Basis for a Framework Agreement on Health Governance*) was reached;
- The *BC Tripartite Framework Agreement* (signed October 13th, 2011 by the federal and provincial governments and BC First Nations) demonstrated participation in planning;
- The establishment of a Tripartite Implementation Committee (representatives appointed by Canada, BC, First Nations) with the mandate to provide general planning and coordination for implementation of the *Framework Agreement* over a five-year timeframe; and, the development of an implementation plan to monitor the implementation of the FA with milestones, activities, expected outcomes, and timelines[41];

[41] British Columbia Tripartite Framework Agreement on First Nation Health Governance (2011-02-101-00001), p. 20

- The establishment of a Transition Team ("to include a senior officer of the FNHS or FNHA, and senior officer of the Health Canada/FNIH Regional Office"), to coordinate activities associated with the Transfer of Federal Health Programs"[42];
- The formation of an Interim Management Committee "consisting of the Regional Director of the Health Canada/FNIH Regional Office and an individual designated by the FNHA" to facilitate transition and learning by FNHA managers of the functions, operations and procedures of the Health Canada/FNIH Regional Office to be assumed by the FNHA"[43]; and
- The level of progress on the Health Actions as demonstrated in "score cards". The most recent (for document review purposes) indicates significant progress in: Maternal and Child Health, where all three score cards show "substantial progress"; eHealth, where one score card shows "substantial progress"; and, Primary Care, where eight out of ten score cards have indicated that work has been initiated and/or in development.[44]

Interview questions addressed both the development and implementation of collaborative approaches and First Nation participation in policy and planning processes of the federal and provincial government. The synthesized answers to these questions are presented below.

Most respondents (n=22) agreed that there has been movement toward service integration and cite the following examples as illustrations of improvement:

- The signed accords by the five BC Regional Health Authorities with the FNHA that represent a strategic alignment and joint planning between the parties;
- Preschool screening initiatives for oral health, vision and hearing; and
- The development and movement forward on health actions (e.g., tele-health, work with high risk young moms, the Aboriginal doula program, the Aboriginal sports and recreation council, extension of physician services in the north).

Some (n=4) respondents cautioned that although the foundation for service integration has been established, much work remained, but most respondents (n=23) agreed that the foundation has been established for improved service access and some early work is evidenced in chronic disease initiatives, the Aboriginal doula program, the H1N1 response, mental health and physician services. A few (n=3) others were undecided and believed that it was too early to tell.

Most respondents (n=22) believed collaboration between parties was an early success and necessary for building consensus. Communication has improved and relationships are building; for example, BC's RHAs and Health Canada were able to work together during the H1N1 crisis to ensure that information and supplies were available on time as needed. Most also mentioned the health accords between First Nation and RHAs as a massive achievement, marking substantial increases in RHAs' engagement. The regional accords have resulted in a level of collaboration on health that is unparalleled.

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[42] Ibid., p. 21
[43] Ibid., p. 21
[44] Score Card on TCA:FNHP 29 Action Items PLUS TFNHP 7 Action Items PLUS 3 new Action Items [from Gathering Wisdom feedback] – February 7, 2012 9 (full document) (2012-01-105-00066)

There is strategic alignment between the parties with respect to the desired health outcomes with the Tripartite First Nations Health Plan that initially had 29 health actions that has expanded to 39, which clearly demonstrates positive intent. Many respondents stated the focus on health promotion is extremely effective.

Many (n=12) respondents mentioned the tripartite data quality and sharing agreement as a victory that may represent one of the best collaborative information sharing agreements nationally. A couple of respondents provided examples such as e-health and health surveillance systems as evidence of early success.

Immediate Outcome Challenges and/or Barriers

The evaluation identified some challenges throughout the tripartite process, such as those noted below.

The following challenges associated with the planning and development of Governance Actions and Health Actions of the Tripartite First Nations Health Plan identified in the February 7, 2012 "Score Card":

- Governance Action #3, *Each Health Authority to develop an Aboriginal Health Plan*: Each Regional Health Authority was tasked with developing an Aboriginal Health Plan. The "Score Card" indicated: "There is much more to be done with aligning RHA plans with First Nations Community Health Plans. Part of the reason…is the absence of Comprehensive Community health plans amongst many First Nations communities, while another is variable engagement between RHAs and First Nations political and technical leaders."[45]
- Health Action #13, *Improve the First Responder program in rural and remote communities*: Not all First Nation communities have current emergency management plans and current pandemic plans. The next steps include: continued support for a province-wide strategy to ensure that all rural and remote communities can access First Responder support as part of Health Action #12; improve primary care services on reserve to match or exceed off-reserve serves; and the FNHA to identify "current status and emerging initiatives and strategies, including community and regional levels."[46]
- TFNHP: *Develop and implement an Injury Prevention and a Health Promotion Strategy*: Teaching materials on injury prevention need to be culturally adapted before they can be made available as resources to First Nations communities.[47]
- New Action, 2009, *Develop a First Nations Pandemic planning approach including H1N1*: During the H1N1 epidemic in BC, it was found that many First Nation communities did not have pandemic plans. As the result of lessons learned from the

[45] Score Card on TCA:FNHP 29 Action Items PLUS TFNHP 7 Action Items PLUS 3 new Action Items [from Gathering Wisdom feedback] – February 7, 2012 9 (full document) (2012-01-105-00066), p. 1
[46] Ibid, p. 6-7
[47] Ibid., p. 9

tripartite response, the issue was raised at Gathering Wisdom forums and there was a call to develop a First Nation Pandemic Planning approach. As a result, many First Nation communities have developed pandemic plans. Ensuring that First Nation communities obtain resources to deliver their plans was identified as a requirement.

A review of progress reports prepared by the First Nations Health Council indicated some challenges were encountered such as bringing together First Nations who traditionally had little contact with each other; First Nations' skepticism about dealing with governments and concern about the proposed changes; lack of sufficient time and resources for constructive consultations with multiple stakeholders; and, the challenges of realigning priorities and resources to respond to unexpected events such as H1N1 influenza pandemic.

Barriers to Collaboration

All respondents (n=23) noted that, in the beginning, BC provincial health care teams expressed concern about participating in the tripartite initiative. RHAs have since implemented Indigenous cultural competency training which has changed how health teams approach the extension of health services to communities on reserve.

Some suggested that each party had a different agenda that could interfere with creating true partnership while many respondents suggested that there was a lack of free flowing information. Some reported that the vision was well communicated at the senior level, while other team members were *'left in the dark'*. Delays in funding and federal decision-making delays, together with unrealistic timelines, all stressed the relationship.

Barriers to Integrated Service Delivery

All (n=23) informants suggested that it took some time for RHAs and other provincial players to commit time and resources to the project because the sheer scope of responsibility and associated financial pressures were intimidating. Other initial setbacks included federal approval procedures, changing established ways of delivering health care and decision-making processes within each of party. Staff turnover, duplication of effort and confusion about tasks associated with the process did not help.

Learning how to communicate in a way that would allow all parties to feel heard and understood, and to engage with one another in culturally appropriate ways, took some time to develop. Identifying priorities and sharing information have progressed substantially but also took a lot of time.

Historical jurisdictional barriers, prevailing negative attitudes towards First Nations (on the part of some individuals), and the lack of cultural competency within the BC health system were all noted barriers to integration. Philosophical differences between the parties put stress on moving forward with integration.

A few respondents suggested that implementing systems change would depend heavily upon whether those systems even existed in the first place. For example, small communities do not have the resources to develop sophisticated health information systems, so integrating health information may first require infrastructure changes.

Immediate Outcome Unintended Findings and/or Consequences

Due to the successes achieved through the tripartite efforts, additional health actions were added to the original Tripartite First Nations Health Plan.

As a first-effort in Canada to develop a Tripartite Framework Agreement, the federal Minister of Health indicated that these successes have resulted in other provinces demonstrating interest in similar types of collaboration, and, that lessons learned could be utilized from the BC Tripartite experience, when considering other (future) arrangements with other jurisdictions.[48]

4.2.2. Core Issue #4: Achievement of Intermediate Outcomes

Intermediate Outcome 1: Achievement of a legally-binding tripartite governance agreement

A legally-binding tripartite governance agreement was achieved on October 13, 2011.

This outcome was fulfilled when the governments of BC, Canada and BC First Nations signed the *BC Tripartite Framework Agreement on First Nation Health Governance.* This agreement legally binds the federal government to transfer the planning, design, management and delivery of First Nations health programs to a new First Nations Health Authority.

Intermediate Outcome 2: Development of a new First Nation health governance structure in BC – a new FNHA

The evaluation found that progress was made towards the establishment of a new First Nations health governance structure in BC.

The document review found that under the *Framework Agreement*, signed in October, 2011, the First Nations Health Society was tasked with taking "the necessary steps to establish the FNHA…through a community engagement process."[49] The Agreement describes the legal commitment for the transfer of responsibility for BC First Nation health programs to a new FNHA, and identifies the minimum requirements for the structure and mandate of that new entity.

The February 7, 2012 "Score Card" reported that the "former FNHS has been transformed into the interim FNHA and is commencing work to implement the new health governance arrangement, including participating in the interim management committee and working with the FNHC on the Implementation Committee and its sub-committees,"[50] as outlined under the *Framework Agreement*.

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[48] Report on Plans and Priorities 2009-2010 (p. 1)
[49] *BC Tripartite Framework Agreement on First Nation Health Governance* (2011-02-101-00001), p. 11
[50] *Score Card* (2012-01-105-00066), p. 4

The sub-questions that addressed this outcome in the key informant interview schedule are related to the specific functions of the emerging governance structure and the factors that facilitated FNHA development.

Governance

Respondents unanimously (n=23) agreed that there have been significant improvements to First Nation's health governance in BC that is sensitive, responsive and fully capable of articulating their health priorities, as well as facilitating the incorporation of Indigenous world views into the policy climate of both provincial and federal governments.

There is a merit-based selection process of board members, there are bylaws in place and First Nations are increasingly seen as professional, credible and serious partners in health. They sit with BC and Health Canada as governance peer partners in health. The most significant change in this regard is the separation of politics (FNHC) and operations (FNHA) in health. In particular, historical political representation in health has been replaced with more community driven representation. Although some felt that the work took much longer than it should have, Health Canada's financial contributions definitely contributed to improved First Nation health governance.

Accountability

All respondents (n=23) agreed that accountability has improved and cited the Tripartite First Nations Health Plan together with associated scorecards on the health actions as a primary example of the ability to report to government and community.

An annual report was widely distributed and Gathering Wisdom was a forum where there was reporting to all key stakeholders on health actions as well as consistent exercises to secure direction from communities. Close to ninety percent of BC Chiefs attended Gathering Wisdom. The BC Medical Officer of Health tracked different health conditions and reported every two years on select indices. There was a tripartite committee that oversaw tracking and performance. Work remains as processes are being developed to evaluate health programs and refine performance tracking.

BC's RHAs have begun visiting First Nation communities to support the visibility of provincial health services to First Nation communities and to support availability of provincial health teams and encourage accountably in service to First Nations people on reserve, however, this approach is not yet universal.

While the development of an effective First Nation governance structure is clear, the conversation would not be complete without a description of facilitating factors in this development. High-level political and management support from all three parties was the most commonly (n=23) cited facilitating factor in the development of FNHA. All parties were able to focus on wellness, prevention and population health in a way that advances a First Nation health agenda. Senior leadership within provincial and federal governments directed their teams to support the vision and this consistent message was instrumental. Building consensus required

extensive community engagement. As a result, there was a strong, clear mandate from First Nations collectively that created genuine regional ownership of the vision. Continuity of First Nations representation (FNHC/FNHA) in particular has also facilitated development.

Finally, funding has been a key factor in the development of the FNHA. Significant start-up funds assisted in the development and maturation of operations.

Intermediate Outcome 3: Transition of Federal Funding (First Nations health programs, services and staff) to a new FNHA

The evaluation found current evidence suggesting that the transition of federal funding to a new FNHA is on track for completion in 2013.

The *BC Tripartite Framework Agreement on First Nation Health Governance*, signed October 13, 2011, states that the "Transfer of Federal Health Programs… shall be completed within two (2) years of signing of this Agreement, or such later time as both Canada and the FNHA agree."[51] With respect to the "Transfer of Federal Health Programs", the FNHA will assume responsibility for the following:

- "the planning, design, management and delivery of one or more First Nations Health Programs to replace Federal Health Programs, subject to and in accordance with the terms of this Agreement, and the Canada Funding Agreement; and
- all administrative, policy and other support functions required to plan, design, manage and deliver or fund the delivery of First Nation Health Programs".

The interviews focused specifically on the 'readiness' of the FNHA to assume all transferred resources from Health Canada in 2013.

A majority (n=12) agreed that the FNHA will be ready for transfer when it occurs. Some strongly agreed stating that an enormous amount of work has been done, the direction and implementation plans are clear and with a professional group of planners and a committed team, FNHA will be ready. Others offered qualified agreement based upon whether the federal and provincial governments will be ready for full transition to full implementation (e.g. transfer and distribution of funding). Flexibility will be needed when the inevitable challenges associated with this first-ever effort arise and contingency plans are in place if more time is needed.

All parties are working extremely hard to get everything in place, much work remains such as: development of transition/implementation and evaluation plans; full operational costing including regional offices; and, an opportunity to identify any additional gaps or opportunities for a smooth transfer. Where collaboration is strong, the transition will happen easily and other areas will be more difficult. In addition, FNHA needs a significant percentage of current FNIH employees to transfer for the transition to be smooth.

Intermediate Outcome Challenges and/or Barriers

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[51] *Framework Agreement* (2011-02-101-00001), p. 19

Overall, challenges in governance and management capacity may be faced by the partners as they work together to facilitate the transition and implement the Framework Agreement.

Risks/Challenges to the implementation of the $17M contribution agreement

As part of its role to identify challenges, Health Canada assessed risks in connection with the $17M provided to assist the FNHS in establishing itself as the final FNHA. These risks, and identified mitigation strategies, highlight numerous challenges facing the FNHA.

The first identified was that FNHS may have difficulty in establishing a final FNHA conducive to transfer. The strategy to address this risk included commitments in the Framework Agreement (s. 4 and schedule 4) concerning the formation of the FNHA, its governance structure, and incorporating documents will be fully addressed through multiple mechanisms. First, these activities form part of the FNHS work plan that was included in the government approved submission. As such, these activities will be revisited regularly as part of the quarterly Health Canada-FNHA updates concerning the $17M Contribution Agreement. Second, the FNHA and Health Canada are already collaborating on the corporate changes that will be necessary to establish the FNHA consistent with the Framework Agreement, and which must be satisfactory to the Department [note: now completed]. Finally, these changes will be reviewed by the Department and the Interdepartmental Assistant Deputy Minister (ADM) Oversight Committee prior to flowing funds through the Canada Funding Agreement. These criteria form a significant incentive for First Nations, as no federal funding will be transferred before the criteria are met.

The second risk identified was unexpected transition costs. For First Nations, the risk is that establishing an effective FNHA could cost more than was estimated by their consultant group. For Health Canada, the risk is that transition will take longer than planned, requiring additional operational funds to continue the departmental transition support. The strategy to address this risk included identifying that First Nations would be expected to manage their costs carefully during the transition period, as the federal commitment provides a maximum of $17M. The Government of BC is also providing funding to the FNHA bilaterally (totaling $83.5M over nine years). For Health Canada, the existing tripartite structures provide ample opportunity for the parties to identify and address challenges as they arise. The transition to the FNHA remains a departmental priority; additional operational funds would be managed internally to the greatest extent possible.

Since October 2011, the FNHA has participated in an Interim Management Committee in preparation to take over services, budgets, programs and operations of First Nations Health BC Region. A level of complexity comes with transitioning such a large organization but the outcomes of taking over legal obligations, service delivery responsibilities and transforming the way BC First Nations receive health care is timely and necessary. During transition the FNHA will focus on ensuring program and service delivery continues as seamless as possible, and that financial obligations to communities and staff are met. Ongoing community engagement, implementing the First Nations Health Governance Structure, and improving corporate operations and processes are additional transition priorities.

Barriers to the development of the FNHA

Challenges encountered in the achievement of intermediate outcomes were explored in the key informant interviews. Barriers to the development of the FNHA as well as barriers to collaboration were addressed. The synthesis of responses is presented below.

Each party had different expectations, priorities, mandates and financial constraints that made collaboration time consuming. Delays in decision-making, information sharing and unrealistic timeframes were all factors hindering the development of the FNHA. A couple of respondents suggested that (First Nations) political pressures and expectations tested development: there was much confusion about the difference between political and operational decisions.

Enhancing health services and health governance simultaneously is a major project. Employee turnover, finding the right candidates to fill necessary positions, delays in resourcing and the rapid rate of explosive growth was challenging to FNHA development. The FNHA has outlined that it will first transition health services, and then work to transform programming based on community input and priorities.

Historically, strong jurisdictional divides between the federal and provincial governments provided barriers. It takes time to re-establish trust and unfortunately mistrust and a sense of potential manipulation still exists. Residual colonial mentality, particularly the belief that First Nations were not capable of solid health governance, challenged the tripartite relationship.

Intermediate Outcome Unintended Findings and/or Consequences

The evaluation found many positive achievements and innovative processes that led to the progress made to date including lessons learned that could be of benefit to potential future similar initiatives.

The partners have developed the capacity to identify and include additional health actions, beyond the original 29 identified in the Tripartite First Nations Health Plan, expanding the scope of work in health promotion, in particular.

In Health Canada's 2009-2010 RPP, the Minister indicated that major steps to secure the future health of First Nations and Inuit were taken in previous years. "In June 2007, Health Canada signed a tripartite health plan with the province of British Columbia and BC First Nations that provides a framework for negotiating a final tripartite agreement on health."

The interviews addressed promising practices and while some of the promising practices that have emerged may have been intended, others emerged organically. The synthesis of responses is shared below.

The majority (n=22) felt that the tripartite processes allowed trust to form and relationships to strengthen. Having a third party independent chair at early meetings and operating in an open and transparent way cultivated partnerships.

An early tripartite communications protocol that clearly outlined what information each party could expect to share would have been beneficial. Meaningful, ongoing partnership outlined in formal collaborative agreements (e.g., accords with RHAs) that have respected the cultural differences of Indigenous people in BC is a definite model for others.

As a direct result of these relationship enhancing strategies, the integration and increased profile of First Nation perspectives on health and wellness into service approaches holds promise, and will benefit all Canadians.

Commitment, passion and participation from high-ranking officials (e.g., Deputy Minister's tables) not only supported the process but may be seen as a necessary condition.

The Tripartite Management Team (i.e., a governance body where tripartite representatives watch over the tripartite process) and the Tripartite Committee on First Nation Health, as well as the First Nation Health Directors Association, were all cited as good governance models. Other examples included ensuring skilled people with shared intent are participating; separating the politics from operations; and sharing information to avoid speculation.

First Nation decision-making and consensus building processes (e.g., Gathering Wisdom Forum and other community engagement activities) are excellent examples to others who are considering a tripartite approach. Other good practices include: take the time necessary to ensure First Nation *'buy-in'* or readiness, look to advance tripartite relationships where a critical momentum of transferred health services already exists, and keep the focus on the future.

Developing First Nations governance is a necessary first step and time is needed to *'get this right'*.

Clear, concise delegation of power and a tracking mechanism for results were supportive practices. In particular, the First Nations Health Plan was cited as a foundational work where the tripartite relationship really *'comes to light'*. The plan provided clear direction, measurable deliverables and a framework for collaboration. For example, work with high risk young moms, tele-health in isolated communities, the coordinated H1N1 response, early childhood screening programs, the Aboriginal sports and recreation council and the Aboriginal doula program have emerged from the health action plan.

Finally, learning from and visiting other jurisdictions (e.g., Alaska), using evidence-based approaches, and the philosophical shift from a reactive, sickness model to a proactive wellness model were considered fundamental.

4.2.3. Core Issue #5: Assessment of Economy and Efficiency

The analysis of resource allocation and utilization found that the resources invested in the FNHA had a positive impact on progress made toward the achievement of the expected outcomes.

The literature review illustrated that investments supporting capacity building, collaboration and partnership tend to ensure success in partnerships between government and community initiatives. Analysis of departmental financial data illustrated that the contribution agreements provided investments in the appropriate areas to support the BC Tripartite Initiative.

The Government of Canada (GoC) Policy on Evaluation (2009) defines the demonstration of efficiency and economy as an assessment of resource utilization in relation to the production of outputs and progress toward expected outcomes.

Within the realm of program activities and FNIHB activities in general, there are considerable difficulties in measuring economy and efficiency in terms of true comparisons, alternatives and attribution, as well as quantifying many of the outcomes.

The following methods were used to assess resource allocation and utilization:

- To address questions about efficiency at the level of program implementation and delivery (activities, outputs), an assessment of available financial data (resource allocation review) was conducted;
- To address questions about economy at the level of program implementation and delivery (activities, outputs), an assessment of available financial data (resource utilization review) was conducted;
- To obtain clarification of data expenditure trends, interviews with key program National Capital Region-Ottawa (NCR) staff were conducted;
- To determine opinions regarding the factors affecting and/or influencing the achievement of outcomes as they relate to resource allocation and/or resource utilization, qualitative data from key stakeholder interviews (community and management-level) was obtained and reviewed ; and
- To identify economies and efficiencies, at least on a theoretical level, a literature review compared similar international efforts with the BC Tripartite approach. A document and review of the literature.

As a truly unique initiative that has evolved over time, these contributions were intended to support overall capacity and engagement of First Nations partners, rather than being associated with a specific program investment within the Department's PAA. Although the overall objectives of these contributions support the strategic objectives, plans and priorities of the Branch and Department, the evolutionary nature of this initiative has meant that direct program outputs-to-outcomes were not specifically pre-defined (beyond those identified by the Tripartite First Nations Health Plan signed in 2007). These circumstances have contributed to an inability to explicitly measure economy and efficiency for this evaluation.
However, the evaluation did aim to provide a general sense of resource allocation and utilization by comparing resource expenditure data with program activities and outputs as they related to the achievement of the expected outcomes. Key stakeholder opinions provided an additional line of limited information on the appropriateness of resource allocation and utilization.

Efficiency
Efficiency of the contribution agreements was determined utilizing a resource allocation assessment.

The following financial data and related analysis provides an overall assessment of the impact of expenditure allocations in the context of resource utilization. This analysis includes an examination of delivery costs (direct and indirect), including cost drivers and, resource allocations.

In some cases, trend data was reviewed to understand how expenditure allocations effected activities and service delivery and, potentially, expected outcomes. However, this was limited in the sense that no specific allocation data was available in the context of expenditures in main themed areas, initiatives, activities or outputs.

Since 2007-08, the recipient received $56M through these two contribution agreements in support of the BC Tripartite initiative. This included: an initial $29M in funding as part of its first contribution agreement, that was later amended in 2010-11 for an additional $10M; and, a $17M contribution agreement signed in 2011-12 to assist the recipient in transitioning to the final FNHA, after the parties signed the Framework Agreement (see Figure 2, below).

The recipient also received funding from Health Canada's BC regional office for funding of specific activities within other programmatic envelopes, as well as funding from the BC provincial government. These additional funds were not in scope for this assessment.

Figure 2: Total Funding by Fiscal Year

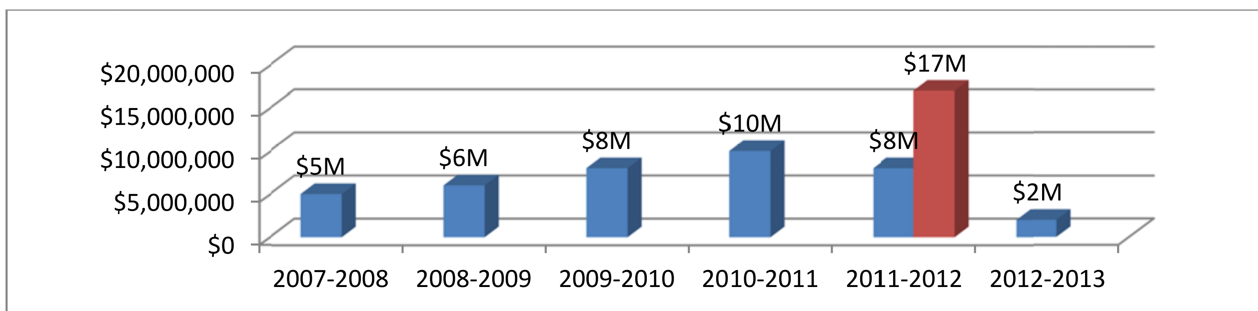

Figure 2 description: This graph represents the amount of funding provided to the recipient for each of the years between 2007-08 and 2012-13. Contribution agreement #1 ($39M) is represented in blue; contribution agreement #2 ($17M) is represented in red.

Further, the final $2M to be flowed to the recipient in 2012-13 had not yet been provided at the time of the evaluation, but will be provided before the end of the fiscal year. Although all funding for the $17M contribution agreement (signed in 2011-12) has been provided, funding did not flow until March 2012, limiting the level of funding available to the recipient for expenditures in that fiscal year.

Key informant information from internal Health Canada stakeholders indicated that the department is very confident, based in part on the unique and close working relationship, and

knowledge of the organization's achievements, that the recipient's fiscal management capacity is strong.

The key elements cited by key informants to improve efficiency were:

- Ensure First Nation capacity development by having the right people with the right skill set do the right work;
- Improve the availability of timely information on real and hidden costs of both health services and administrative activities including cost drivers and baseline health information (surveillance, health status, etc.) in order to drive priority setting and change management strategies;
- Ensure teams have First Nation community/culture knowledge and expertise from the beginning and cultivate a climate of more open communication to facilitate change management
- Improve on collaboration and partnership building;
- Ensure timely decision making with related negotiating authority; and
- Improve communication processes.

Economy

Economy of the contribution agreements was determined with a resource utilization assessment.

Under the original contribution agreement of $39M, major activities were implemented under three main areas including: overall governance; relationship building and accountability; and efforts to address health actions all jointly identified under the Tripartite First Nations Health Plan of 2007.

Examples of activities and outputs included:

- The establishment of a First Nations Health Council, First Nations Health Advisory Committee (now the Tripartite Committee on First Nations Health), province-wide health partners group, and a First Nation Health Directors Association which all support the development of the BC First Nations Health Authority;
- Development of a reciprocal accountability framework (RAF); and,
- Progress on specific health actions under the broader category of primary care and public health which include initiatives that address disease and injury prevention as well as chronic illness and disease.

Under the contribution agreement of $17M, primary focus was in building the structural and operational capacity for the FNHS to evolve into the FNHA. As such, activities and outputs identified in the recipient's work plan primarily consisted of:

- Participation in partner/committee meetings;
- Establishment of the FNHA's new organizational and governance structure;
- Implementation, transition, health program, and financial planning;
- Negotiating the tripartite Health Partnership Accord; and,
- Negotiations of various sub-agreements to facilitate the transfer and related activities (such as human resources, information management/sharing, assets and software/information technology, real property and accommodations, etc.).

A review of the expenditures across the years covered in the evaluation indicated that the organization took a couple of years to reach their capacity to expend the funding provided.[52]

It should be noted that the funded recipient is in a Block funding model, meaning that the department supports its management of the funds between various authorities, and across various programs. Block recipients determine their own priorities and have the authority to keep a surplus if it will be reinvested in health. Recipients are also encouraged to seek other sources of funding.

Funding for the $17M contribution agreement did not flow until March 2012, limiting the level of funding available to the recipient to spend in the first fiscal year. The FNHA's financial reports indicated expenditures of $90K in 2011-12, and an additional $90K in the first three months of 2012-13.

In preparation for transfer, the FNHA must enter financial contractual commitments for large components of the transfer, such as IT systems, leases, IT licenses, contractors, etc. The parties have acknowledged that the transfer date and related transfer funding (through the upcoming Canada Funding Agreement (CFA) will be formally confirmed by the federal government before the FNHA makes these financial commitments. Although Health Canada will not flow CFA funding until the transfer date, the parties plan to sign the CFA in escrow, in advance of the transfer date (following federal approvals).

This will provide financial certainty to the FNHA, allowing its completion of critical areas of implementation such as preparing for the hiring of Health Canada regional employees and signing various provider contracts, lease agreements, and systems and software arrangements. The FNHA's spending of the $17M is therefore minimal, until federal confirmation of transfer (and the related approval of the Canada Funding Agreement) is finalized. As part of this ongoing engagement, the FNHA has provided Health Canada with an updated work plan and budget plan, outlining its upcoming activities and expenditures.

From a review of the documentation and supported by KI interviews, it should be noted that the establishment of a strong and respected health governance organization by First Nations ensured that funding was utilized economically from the start.

Perspectives from Key Informants

As part of the process for assessing resource allocation and utilization, interviews were conducted with key (NCR) program staff as well as regional (BC) staff, including project leads. This enabled follow-up of an initial analysis of data and clarification on some trends identified, and explanations for others.

Key internal and external stakeholders were included in this evaluation through specific in-person interviews. Although the focus was primarily on performance, some information was

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[52] The data in Figure 2 assumes full expenditures of the $10M amendment to the first CA and full expenditure of the $17M second CA. KI information indicates that this is a fair expectation as the FNHS moves towards transitioning to the FNHA.

gleaned regarding the financial management of the contribution agreements. Stakeholders indicated that, as a precedent setting initiative, it is difficult to discern if the most efficient or economical means of achieving objectives had occurred. However, all those interviewed agreed that overall, the contribution agreements were pivotal in achieving the expected results.

Other indicators of economy included:

- The expansion in the breadth and scope of tripartite planning suggested positive will and leveraging of available resources.
- Having the 'right' people with the 'right' skill set to do the 'right' work was seen as a good investment. Transition and implementation committees were credited with having open, honest and spirited discussion that has allowed for greater alignment of priorities.

Key informants did provide their perspectives on how to improve economy in the future including:

- Address the type of funding models with communities given that open-ended funding for the tripartite process has now set high expectations for continued flexibility, which might not be possible in all or most contribution agreements by the FNHA with future community funding initiatives;
- Engage in the transfer process where only partial operations would be transferred to a First Nations health governance structure over a longer period of time and have a built in evaluation plan of the process of tripartite negotiations from the outset;
- Ensure clarity and transparency with respect to expected deliverables; and
- Ensure flexibility within contribution agreements to better reflect the nature of the health governance structure.

Literature Review

The literature provided general evidence on the need and effectiveness of self-determination in health, as well as overall policy support for health delivery approaches that include varying degrees of indigenous involvement.

The literature found overall support for the direction of increased self-determination and local control over health resources, as reflected in the approach taken by the BC Tripartite Initiative. Scholarly sources (e.g. see Belanger, 2011; Lavoie et al, 2010c; Dalton, 2005) have indicated the policy and rights-based needs for more self-determination (within the context of self-governance) have tended to indicate that best approaches (i.e., local capacity to take increased control) need to be in place[53], but that the broader and longer-term implications are not yet known.

[53] Shwartz et al, 2002; Wamai, 2009

5. CONCLUSIONS AND IMPLICATIONS

The synthesis and analysis of the findings from this evaluation resulted in conclusions about both the relevance and performance of the BC Tripartite contribution agreements. This section also describes the implications of the evaluation and highlights lessons learned.

5.1. Conclusions

Relevance

Health Canada's contribution funding to this recipient enabled its engagement in tripartite activities and its movement towards assuming the design, management and delivery of First Nations health programming in BC.

The federal government agreed early in 2007-08 to join and support the move towards a new First Nation health governance structure in BC. The need to support this initiative with contribution funding was pertinent in order to enable BC First Nation engagement in the BC tripartite process.

These contribution agreements were appropriate in that they aligned well with federal government priorities and departmental strategic priorities and outcomes. Furthermore, support to the BC First Nation Health Authority with contribution funding aligned with federal roles and responsibilities to support and strengthen First Nations participation in policy and planning for the delivery of health services. More specifically, the contribution agreements were necessary within the context of the BC First Nations efforts to establish a First Nations Health Authority in partnership with both provincial and federal governments.

Performance: Effectiveness

The FNHA has advanced in establishing the appropriate frameworks, operational structures and planning processes toward its transition and implementation.

Of primary focus for the Tripartite Initiative was the need for tripartite partners to work together in a collaborative manner in order to build a new health governance structure in which BC First Nations would plan, design, manage and deliver First Nation health programs and services. Over the period of the contribution agreements, collaborative health program approaches and mechanisms between delivery partners have been established and partners have worked to build 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.

The progress made to date was initiated by the successful development of the Tripartite First Nations Health Plan and realized by First Nation capacity development in leadership, planning, and organizational development as well as successes in collaborative partnerships and innovative decision-making mechanisms. These achievements have been supported through the steadfast partnership, commitment and shared vision of all players. These achievements are further illustrated by the progress made in jointly identifying and setting priorities and objectives as articulated in signed agreements. These agreements have set a strong foundation to address the need to further develop integrated service delivery for BC First Nation communities.

Efforts since 2007-08 have culminated in the signing of the *BC Tripartite Framework Agreement on First Nation Health Governance* and the establishment of a strong BC First Nations health governance structure which is on track to transition responsibility for the program design, management and delivery to the BC First Nations Health Authority in 2013.

Performance: Economy and Efficiency
The contribution agreements demonstrate a sound investment strategy that supports the success of the recipient's involvement in the Tripartite Initiative.

The BC tripartite contribution agreements, that supported initial consultations and ongoing capacity development, were a positive step to achieving the expected outcomes. The funding assisted in identifying and supporting approaches for collaboration, integration and local capacity for increased involvement in decision-making. The type and level of funding to the First Nations Health Authority supported the achievement of the expected outcomes.

5.2. Implications

Formal recommendations are not being proposed for this evaluation given that the contribution agreements are winding down and Health Canada will evolve into its role as funder and governance partner, with ongoing commitments outlined in the Framework Agreement and the proposed Canada Funding Agreement.

Health Canada's ongoing commitments include: participating in and supporting the new governance relationship; fostering integration between First Nations and provincial health programming where possible; supporting capacity development of BC First Nations; and, supporting robust reporting among the three partners.

Based on the findings and conclusions outlined in this evaluation report, the department is aware that there are lessons learned that will be valuable to consider in future tripartite activities.

6. Lessons Learned

The consistent partnership, commitment and shared vision of all players were instrumental to the progress made to date. The evaluation found many positive achievements and innovative processes that led to the successes and progress made to date. These included a tripartite process that:

- Built on previous tripartite partnership efforts to establish frameworks to address FN health governance and included lessons learned from other jurisdiction;
- Established a common, shared vision from the outset;
- Fostered trust and strengthened relationships between partners through active, committed and passionate engagement by high-ranking officials;
- Outlined partnership roles and responsibilities in formal collaborative agreements;

- Established a governance body and operational mechanisms to develop and implement actions with clear, concise delegation of power, while ensuring the separation of political and operational mandates as well a timely decision-making;
- Named a third-party independent chair at the early stages allowing for transparency and cultivating strong partnerships;
- Established strong communications protocols and frequent dialogue; and
- Ensured participation and engagement of skilled and knowledgeable individuals as appropriate.

The evaluation highlights lessons learned reflecting the various stages of the tripartite initiative over the last several years. These could be applied to future partner collaboration, capacity building, and integration. The lessons summarized below included the need to ensure:

- Improved emergency management and pandemic planning at the community level;
- Sufficient time and resources to engage in constructive consultations with multiple stakeholders.
- Staff training to facilitate integration of provincial and on-reserve health programming;
- Regular and free flow of information among the partners.
- Consideration of each party's decision-making processes and timelines.
- Support for early development of First Nations' planning and risk management functions.
- Collaborative effort to integrate service delivery, including changing established ways of delivering health care, communicating and engaging in culturally appropriate ways, and identifying priorities.

APPENDIX A: TECHNICAL ANNEX

Tripartite Overview
In 2005, BC First Nations and the Government of BC began to collaborate toward the improvement of First Nations health in BC. This began with the *Transformative Change Accord*, endorsed by both parties (and endorsed by the Government of Canada).

In 2006, the federal government joined the discussions. The three parties signed a Memorandum of Understanding (MOU) to develop a *Tripartite First Nations Health Plan*. The MOU initiated a collaborative tripartite partnership to improve the health of BC First Nations and their communities, identifying areas of mutual interest.

In 2007, the three parties completed and signed the *Tripartite First Nations Health Plan* in order to create fundamental change to improve First Nations health status, define principles to design a new governance system, and establish goals for implementation. The 29 health actions identified in the *Tripartite First Nations Health Plan* focus on health-related initiatives, within four main 'streams': Governance, Relationships and Accountability; Health Promotion/Disease and Injury Prevention; Health Services; and, Performance Tracking.

Following the signing of the *2007 Tripartite First Nations Health Plan*, Health Canada committed to provide $29M over four years of internal funds (2007-08 to 2010-11) to support BC First Nations in engaging in the development and implementation the 29 health action items identified in the Tripartite First Nations Health Plan. This internal departmental allocation was provided through a CA managed at the regional level, under the previous First Nations and Inuit Health Governance and Infrastructure Support Authority (now called the Health Infrastructure Support Authority).

In 2008, the federal Minister of Health began negotiations on First Nations health governance in BC and one other jurisdiction, including the basis for a federal financial offer to be made to a new First Nations governance body.

In the spring of 2010, the three parties reached and signed an agreement-in-principle (*BC Tripartite First Nation Health: Basis for a Framework Agreement on Health Governance*). Health Canada provided an additional $10M over two fiscal years (2011-12 and 2012-13) to BC First Nations. This funding was amended to the $29M contribution already provided in 2007-08.

In 2011, the Minister signed the *BC Tripartite Framework Agreement on First Nation Health Governance*, which included $17M as the federal contribution toward the implementation and transition costs of the First Nations Health Society to establish itself as the final First Nations Health Authority, including supporting its operations, and the eventual transition of programs, services and functions to its management.

At a ceremony in Vancouver on October 13, 2011, the federal and provincial Ministers of Health, and BC First Nations signed the legally-binding Funding Agreement (FA). The FA commits the Parties to work together toward transitioning federal First Nations health programs, services, and staff to the FNHA within two-years, or at a later date if agreed to by the parties.

The FA is intended to:

- Build a new governance structure that avoids separate and parallel First Nations and non-First Nations health systems. The key feature of this new structure will be a FNHA to plan, design, manage, deliver and fund the delivery of First Nations health programs and services;
- Transfer of federal funding and staff for First Nations health programs to the FNHA,;
- Build a more integrated health system for First Nations under the new governance structure;
- Require the active participation of Canada and BC in the new governance structure, as part of the wider partnership with BC First Nations; and
- Shift the federal role away from day-to-day operational responsibilities toward that of a funder and governance partner.

The transfer includes funding for programs and services currently provided or funded by Health Canada for First Nations in BC, as described in the FA, including programs for children and youth, chronic disease, primary care, communicable disease control, mental health, environmental, governance, facilities/capital, Indian residential schools and Non-Insured Health Benefits.

The Parties agreed that the implementation of the FA will occur within two years, or such later time and manner as both Canada and the FNHA agree. The Tripartite Governance Structure outlined in the FA will continue to monitor progress on the joint implementation plans, work plans, and targeted deliverables, making adjustments if necessary.

The overall goals for the BC Tripartite Initiative include:

- Fundamental change leading to improved health status
- A new governance system for First Nations health
  - Health services that meet the needs and priorities of First Nations
  - Health Canada moves from designer and deliverer to funder and governance partner
  - First Nations health services linked and coordinated with provincial services (i.e., no duplication; No parallel health systems)
- A more effective and efficient system for all involved in First Nation health governance
  - Access addressed
  - Gaps closed
  - Improved accountability

Tripartite Partners

BC First Nations

In 2007, the FNHC was established by the three political First Nation organizations in BC – the *First Nations Summit*, the *Union of BC Indian Chiefs*, and the *BC Assembly of First Nations* – with a mandate that included direction and oversight of tripartite negotiations on health. As the tripartite process evolved, so did the BC First Nations organizational structure. The FNHC initially had a membership composed of these three political bodies. However, in 2010 the three political organizations revised the FNHC's membership. Its 15 members are now designated by five First Nations regions covering the entire province (contiguous with the boundaries of BC's Regional Health Authorities). FNHC is accountable to BC First Nations through this regional structure, and provides reports to the three First Nations political bodies.

The FNHS began as a small operational arm embedded within the First Nations political bodies in BC. However, with the growing demands of tripartite governance work, the FNHS expanded, hiring several professional directors. In 2009 it was legally formalized as the operating business arm of the FNHC, with significant expertise in health care and financial management. The FNHS, acting on behalf of the FNHC, is accountable to all BC First Nations and provides public reporting.

The FNHS received its mandates from BC First Nations chiefs through all-cheifs assemblies entitled Gathering Wisdom. These are rigorous and thorough processes through which BC Chiefs and their communities have opportunities to review and comment on proposals to establish the permanent structure of the FNHA and are eligible to vote in decision-making fora.

The FNHS received a mandate to sign the FA and become the interim FNHA (iFNHA) as per the Resolution passed at the BC All Chiefs Assembly in May 2011 (*Gathering Wisdom IV*). The Resolution indicated: "…that the First Nations Health Society is to take steps to become the interim FNHA and begin the early steps in implementing the new health governance arrangement". At that meeting, over 87% of attending Chiefs and proxies voted to support the Resolution. Leaders also subsequently undertook further discussions and expanded the number of Chiefs who supported the Resolution.

The iFNHA received a mandate to become the permanent structure of the FNHA as per the Resolution passed at the BC All Chiefs Assembly in May 2012 (*Gathering Wisdom V*) based on 94% support of attending Chiefs and proxies.

In August 2012, the iFNHA made the necessary revisions to its name, constitution, and bylaws under BC law to become the final FNHA. The FNHA now operates in its full legal capacity to assume the design, management and delivery of First Nations health programming in BC, once transition activities among the parties are complete.

The FNHS, iFNHA, and FNHA are the same organization, only with a different name and some constitutional and bylaw changes to reflect its evolving role and progress toward the transfer.

Government of BC

In BC, an opportunity to work with willing partners emerged based on strong support from Premier Campbell for a new relationship with First Nations and strong First Nations capacity and leadership. Under this leadership, BC negotiated the 2005 *Transformative Change Accord* with BC First Nations which set out a plan to improve provincial-First Nations collaboration and First Nations health.

The federal government had been involved in discussions in 2005, but the Accord was re-released by BC First Nations and Government of BC after the 2006 federal election.

In 2007 the Governments of Canada, BC and BC First Nations signed a *Tripartite First Nations Health Plan*, committing the parties to jointly explore new priorities and processes, including a new First Nations health governance structure. The Government of BC was engaged in the development of this Health Plan before the Government of Canada joined the process.

In addition, the Tripartite Committee on First Nations Health is co-chaired by the BC Deputy Minister of Health (BC), BC First Nations, and the ADM-FNIHB of Health Canada. Committee members include presidents/chief executive officers (CEOs) of the BC Regional Health Authorities.

This Committee coordinates First Nation health planning, programming, and service delivery. It is the key instrument to co-ordinate and integrates the services of the FNHA and those of the provincial Regional Health Authorities. It reports annually to Ministers and FNHC on progress of integration and improvement of health services for First Nations in BC.

Also, the Government of BC has made commitments to: direct its Health Authorities to develop collaborative working relationships with First Nations, achieve better coordination, and discuss innovative arrangements for service delivery; establish a new First Nations Medical Health Officer empowered under Public Health Act of BC; and, provide funding to BC First Nations of at least $100M over 10 years.

Federal Government

The federal government is a partner in the delivery of health services and programs to First Nations. The federal government agreed to join the bilateral discussions on First Nation health and effectively changed the arrangement to be tripartite: a partnership with the government of BC, BC First Nations and HC.

These efforts led to the development of the *Tripartite First Nations Health Plan,* which focusses on the implementation of the 39 health actions and supports First Nation health governance capacity to eventually move to the implementation of a BC FNHA, consistent with previous tripartite agreements, and lead to the signing of the legally-binding *Tripartite Framework Agreement on First Nation Health Governance*.

Tripartite Agreements

For the years included in this evaluation, Health Canada has signed the following tripartite agreements:

2006

- Tripartite MOU to develop a *Tripartite First Nations Health Plan.*

2007

- *Tripartite First Nations Health Plan* in order to create fundamental change to improve First Nations health status and define principles to design a new governance system.
- Health Canada provides contribution funding ($29M over 4 years) to *First Nations Summit Society* later renamed *First Nations Health Society* (FNHS).

2010

- Tripartite agreement-in-principle (Basis for a Framework Agreement on Health Governance) was reached.

2011

- On October 13, 2011 the legally binding Tripartite FA was signed by the federal and provincial Ministers of Health and the BC FNHS, with endorsement from the BC FNHC.
- Health Canada amends the $29M CA with FNHS, adding an additional $10M over 2 years (2011-12, 2012-13) to support ongoing work on the Tripartite First Nations Health Plan.
- Health Canada provides $17M CA to FNHS (now renamed FNHA) for implementation of the FA.

2012

- In December 2012 the three parties signed the Tripartite Health Partnership Accord as committed in the Framework Agreement. The Accord describes the mutual commitment to ongoing collaboration.

Data Collection Analysis Issues

Documentation and Literature Review [54]

Program documents were obtained from the FNIHB National Capital Region (NCR) and BC regional staff. These included administrative records, annual reports, work plans, program files, audits and other relevant material that both described and documented progress over time. The document review was conducted by an independent contractor.

Internet-based literature searches were conducted for the purpose of supporting the assessment of economy and efficiency. Literature identified other relevant Canadian and international reports, strategies, and evaluations, including non-First Nations initiatives. Data relevant to the indicators was extracted.

[54] 'Documentation' refers to documents internal to Health Canada and/or FNIHB. 'Literature' refers to information prepared by sources outside FNIHB and Health Canada - for example, web pages and reports of other relevant organizations, published studies and other international literature.

Key Informant (KI) Interviews[55]

Key internal and external informants, with a purposefully selected sample (n=23), were interviewed individually based on the evaluation matrix performance indicators.

An interview guide was developed which outlined all of the ethical and legal obligations of the contractor as well as the interview questions and was provided to each interviewee at least four days in advance of the interview.

Key Informant (KI) interviews focused only on the achievement of expected outcomes and a demonstration of economy and efficiency. It was agreed that the small selected sample of stakeholders would not shed further insight on relevance beyond what was found in the document review.

Assessment of Economy and Efficiency[56]

The assessment for economy and efficiency was based on financial data provided by Health Canada's Branch Financial Services Office (BFSO), a review of audited financial statements from the BC First Nations Health Society, and interviews with national and regional program staff. This assessment was conducted internally by a senior evaluation analyst.

Multiple Lines of Evidence

Gathering multiple pieces of corroborating evidence helps improve the quality of certain data. As described above, the evaluation methods relied on more than one line of evidence. Most evaluation questions were addressed through multiple lines of evidence, as determined through a cross-walk and data collection template.

Ethical/Human Subject Protection Issues and Protocol

Ethical and human subject protection principles were upheld in survey administration, data management, and reporting processes. Participation in the KI interviews was voluntary.

Metadata was only provided by the contractors, and all personal or identifying information was kept confidential. Responses are presented in summary form within this Evaluation Report. The information collected was not disclosed to external third parties, as specified by the *Privacy Act*.

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55 This line of evidence is supported by a technical report. Not all data from these reports are necessarily presented in detail in this report.

56 Ibid

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