QUEBEC FIRST NATIONS' HEALTH AND SOCIAL SERVICES GOVERNANCE PROCESS

LEGAL FRAMEWORK FOR ORGANIZING AND PROVIDING HEALTH SERVICES FOR QUEBEC FIRST NATIONS

Report produced by the First Nations of Quebec and Labrador Health and Social Services Commission

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

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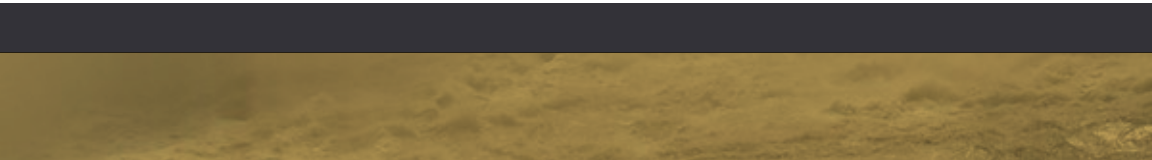

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LIST OF ACRONYMS

AFNQL	Assembly of First Nations Quebec-Labrador
ATHC	Alaska Tribal Health Compact
CLSC	Local Community Health Centre
CPDP	Council of Physicians, Dentists and Pharmacists
CYFN	Council of Yukon Firsts Nations
DHB	District Health Board
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNIHB	First Nations and Inuit Health Branch
FNQLHSSC	First Nations of Quebec and Labrador Health and Social Services Commission
FSIN	Federation of Sovereign Indigenous Nations (formerly Federation of Saskatchewan Indian Nations)
JBNQA	*James Bay and Northern Quebec Agreement*
NIHB	Non-insured Health Benefits
RAMQ	Régie de l'assurance maladie du Québec
YHC	Yukon Hospital Corporation

INTRODUCTION

This report contains the preliminary results of Corpus B[1] entitled *Legal Framework for Organizing and Providing Health Services for First Nations in Quebec* resulting from the *First Nations in Quebec Health and Social Services Governance Project* (hereinafter "the Project"). Led by the First Nations of Quebec and Labrador Health and Social Services Commission[2] (FNQLHSSC), the Project seeks to improve the provision of and access to health and social services at the local and regional levels through the implementation of a governance model adapted to the needs and circumstances of First Nations. At the pre-General Assembly on July 8, 2015, the communities agreed to define "governance" as follows:

> The traditions (norms, values, culture, and language) and institutions (formal structures, organization, and practices) a community uses to make decisions and achieve its goals. The concept of governance is based on the creation of efficient, responsible, and legitimate systems and processes that allow citizens to express their interests, exercise their rights, fulfil their obligations, and reconcile their differences.[3]

Although this concept will be studied more broadly as part of the final report, we should mention that health governance reflects the power to act in terms of the organization, funding, access to, and provision of health care for First Nations. First Nations in Quebec are convinced such an approach to governance will help them improve their health.[4]

Our objective is to equip First Nations to choose governance models taking into account the needs and circumstances of each Nation and the current governance model, which is presented in this preliminary report. More specifically, the report, seeks to highlight the legal framework for providing and delivering health care to First Nations as well as the processes envisaged in terms of autonomy. The goal is to see if and how the voice of First Nations can be heard in the current system.

1 The FNQLHSSC project includes three corpora (A, B, and C) that will be brought together in one final document. Corpus A looks at the health governance models that can or cannot be implemented, constitutionally, in Quebec. Corpus B, this report, highlights the legal framework for offering and delivering healthcare to First Nations as well as the processes envisaged in terms of autonomy. The goal is to see if and how the voice of First Nations can be heard in the current system. Finally, Corpus C looks at First Nations' right of governance in more detail and analyzes all the corpora.

2 FNQLHSSC is a non-profit organization responsible for supporting the efforts of First Nations in Quebec and Labrador in order to, among other things, plan and deliver culturally appropriate preventive health and social services programs. See the FNQLHSSC website: First Nations of Quebec and Labrador Health and Social Services Commission, *About Us*, online: ‹http://cssspnql.com/en/about-us› (consulted April 7, 2015).

3 This definition is adapted from the definition provided by the Centre for First Nations Governance. First Nations of Quebec and Labrador Health and Social Services Commission, *Summary Report of the pre-General Assembly*, Québec City, July 8, 2015, forthcoming (italics ours).

4 FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION, *First Nations in Quebec Health and Social Services Governance Project—Better Governance, Greater Wellbeing*, by Daniel Wilson, Québec City, 2015, p. 5, online: http://www.cssspnql.com/docs/default-source/Publications-Gouvernance/css_1509_gouvern_wilson_an_webf.pdf?sfvrsn=2›

In 1985 the Quebec National Assembly adopted a resolution recognizing the rights of aboriginal people.[5] At the same time, the resolution confirmed the right to self-government for ten First Nations (Abenaki, Algonquin, Atikamekw, Cree, Huron-Wendat, Innu [Montagnais], Maliseet, Micmac, Mohawk, and Naskapi) and Inuit in Quebec.[6]

Today, self-government is still a topic of debate, particularly in terms of health, while the role of First Nations in organizing and delivering healthcare programs remains minimal.[7] The uniqueness of First Nations requires a method of governance consistent with their needs and organizational expectations, in compliance with current constitutional rules. This does not appear to be the case today. The legal framework governing the provision of and access to healthcare for Quebec First Nations is complex, involving constitutional norms, federal and provincial laws, principles, and various agreements. Moreover, a large number of stakeholders are directly affected, namely, provincial and federal governments, bodies representing First Nations,[8] as well as band councils and other community entities. In practice, the organization of health care for First Nations has resulted in numerous dysfunctions. Two such deficiencies observed by FNQLHSSC are a lack of willingness to involve First Nations in decision making and grey areas in terms of responsibility for healthcare services.[9] According to FNQLHSSC, the current top-down approach does not recognize—or barely recognizes—First Nations' right to self-determination with respect to the health programs and services available to them.[10]

Our research seeks to answer the following: Does the current state of law allow First Nations to claim greater autonomy, the "power to act" in the organization, funding, access to, and provision of health services available to them?

To find the answer, we needed to review legislation, regulations, norms, policy statements, and doctrine related to the organization and provision of health care to Quebec First Nations, to establish the applicable framework. The results of our research have been compared to the situation of the Cree in Quebec, as they have their own governance for health care. In light of this data, healthcare governance initiatives implemented elsewhere in Canada (Alberta, British Columbia, Saskatchewan, and the Yukon) and abroad (Alaska,

5 QUEBEC NATIONAL ASSEMBLY, *Resolution of the Québec National Assembly dated March 20, 1985, on the recognition of existing aboriginal rights and resolution dated May 30, 1989, recognizing the existence of the Maliseet Nation*, Québec City, 1985, online: <http://www.apnql-afnql.com/en/publications/pdf/Declaration-Assemblee%20nationale-en.pdf>.

6 QUEBEC MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *Delivery and funding of health services and social services for aboriginal people (First Nations and Inuit)*, Québec City, 2007, p. 5, online: <http://publications.msss.gouv.qc.ca/msss/fichiers/2007/07-725-02A.pdf>.

7 First Nations of Quebec and Labrador Health and Social Services Commission, *op. cit.*, Note 4, p. 10.

8 FNQLHSSC is responsible for representing the voice of Quebec First Nations in the province and beyond. FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION, *2014–2017 Strategic Plan*, Québec City, 2014, p. 11, online: <https://www.cssspnql.com/docs/default-source/centre-de-documentation/plan-et-enjeux-ang.pdf?sfvrsn=2>.

9 *Ibid.*

10 FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION, BLUEPRINT – QUEBEC FIRST NATIONS HEALTH AND SOCIAL SERVICES – 2007–2017, detailed version, Québec City, 2007, p. 17, online: <http://www.cssspnql.com/docs/centre-de-documentation/final-ang.pdf?sfvrsn=2>.

New Zealand) have been analyzed in their pre-and post-adoption contexts, with a view to assessing potential applicability to Quebec First Nations. In addition, national representatives were consulted on two occasions to suggest legal avenues consistent with Quebec First Nations' wishes.[11]

The report is divided into three chapters. The first identifies and analyzes the nature, scope, and limitations of the legal norms granting or capable of granting, particularly in terms of constitutional requirements, First Nations the power to act on health. The second chapter presents the observations made after consulting with certain First Nations and in light of the literature obtained. The third and final chapter sets out the options that could meet the needs and expectations of Quebec First Nations, based on the legal framework established in the first two chapters. We will also present and analyze more advanced governance models that have been put in place in other Canadian provinces and abroad. The aim is to determine whether these models could be transposed to Quebec, given their scope, the legal norms involved, and the pre- and post-adoption governance context. However, all models require an agreement between Nations and a partnership with the government(s).

11 Our work involved meeting with managers of certain health centres. We prefer not to name them to maintain the objectivity of those reading our report.

1
THE CURRENT FRAMEWORK FOR AUTONOMY

INTRODUCTION

In Canada, all legal norms must comply with constitutional requirements, i.e., they must respect the shared jurisdiction of the provincial legislatures and the Federal Parliament established by *The Constitutional Act, 1867*.[12] Regarding health care for Quebec First Nations, the legal norms divide responsibility between the Government of Quebec and the federal government according to the legal nature and factual situation of the Nation. Depending on whether it involves so called non-agreement Nations[13] (or on reserves) or agreement Nations, either the federal government and/or the Government of Quebec will have jurisdiction (Table 1, below).

Without going into detail, because this will be discussed in the first chapter, we must specify from the start that the Federal Parliament has exclusive authority over "Indians, and Lands reserved for the Indians."[14] This means the Federal Parliament administers, delivers, and funds primary and emergency health services, as well as community health services for Nations on reserves.[15] Medical care and specialized or subspecialized care are managed by the provincial system. Moreover, this has allowed the federal health ministry, Health Canada, to implement the Non-insured Health Benefits (NIHB) program[16] offering Canadian First Nations coverage for health services that are not provided under insurance from provinces and territories. In this way all First Nations, even those living on a reserve, benefit from the federal government's NIHB. Specifically, the federal government pays for medications, vision care, dental care, and medical equipment. At this stage we simply need to note that these federal services[17] can be provided through contribution agreements or transfer payments.[18] Outside reserves, the Government of Quebec develops, organizes, and provides health services to all Quebecers, including First Nations[19] pursuant to its constitutional jurisdiction provided for in *The Constitutional*

12 *The Constitutional Act, 1867*, 30 & 31 Vict., c. 3 (UK), Sections 91 and 92.

13 There are two types of non-agreement Nations—those on an "Indian reserve" and those living in an "Indian settlement." QUÉBEC MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, Note 6, p. 4.

14 *Constitutional Act, 1867, op. cit.*, Note 12, Subsection 91(24). Regarding whether Inuit people are included in the term "Indians," see *Re, Eskimos*, [1939] SCR 104.

15 HEALTH CANADA, *First Nations and Inuit Strategic Health Plan: A Shared Path to Improved Health*, First Nations and Inuit Health Branch, Ottawa, 2012, p. 6 and 7, online: <http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/pdf/pubs/strat-plan-2012/strat-plan-2012-eng.pdf>.

16 *Constitutional Act, 1867, op. cit.*, Note 12, Subsection 91(24).

17 QUEBEC MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, Note 6, p. 6 and 7.

18 See the Health Canada website: <www.hc.sc.gc.ca> (consulted April 7, 2015).

19 HEALTH CANADA, *op. cit.*, Note 15, p. 7.

Act, 1867.[20] Just like all residents of Quebec, First Nations living outside communities, i.e., those living in urban environments, receive medical and hospital care provided by the Quebec health and social services network.

Given the lack of rules governing the legal situation of non-agreement First Nations, this chapter seeks to present the powers for taking action on health granted to First Nations located within non-agreement Nations.[21]

Table 1: Division of Responsibilities for Health Services Granted to First Nations

	Non-agreement Nations (living on a reserve)	Agreement Nations—Cree, Inuit, and Naskapi	First Nations outside a community
Funding for insured health benefits	Fed. govt.: - primary care - emergency care - community care Quebec govt. (RAMQ): - medical care - specialized care - subspecialized care	Quebec govt.: - in general (RAMQ) Fed. govt.: - for certain community health programs	Quebec govt. (RAMQ)
Funding for non-insured health benefits	Fed. govt. (NIHB)	Quebec govt. (per the same rules as NIHB) - unless certain internal rules apply	Fed. govt.
Non-medical health services	First Nation Bodies or Fed. Govt.	First Nation Bodies (see Chapter 2 of the report)	Quebec govt.
Organization of health services	Fed. govt. or First Nation bodies	First Nation Bodies (see Chapter 2 of the report)	Quebec govt.
Development of health programs	Fed. govt. or First Nation bodies	First Nation Bodies	Quebec govt.

* We are defining "First Nations outside communities" as people from First Nations who live in urban environments and not in a community (whether under agreement or not).

1.1 PROVINCIAL LAWS OF GENERAL APPLICATION

This section sets out and analyzes the provincial laws (Subsection 1.1.1) and ministerial principles (Subsection 1.1.2) that promote autonomy for First Nations regarding health.

20 *Constitutional Act, 1867, op. cit.*, Note 12, Subsections 92(7), 92(13) and 92(16).

21 We must keep in mind, however, that the situation of agreement Nations, the Cree Nation for example, is used in several points of comparison in the third chapter.

1.1.1
Scope and Limitations of Provincial Laws

In general the Government of Quebec develops, organizes, and delivers health services to all Quebecers, including First Nations,[22] pursuant to its constitutional jurisdiction provided for in *The Constitutional Act, 1867*.[23] This allows the Parliament of Quebec to give all Quebecers access to health care offered by the provincial health system and specifies the organizational method for the Quebec health network.

As we have stated, just like all residents of Quebec, First Nations living outside communities receive medical and hospital care provided by the Quebec health and social services network. The provisions of the *Health Insurance Act*,[24] the *Hospital Insurance Act*,[25] and the *Regulation respecting the application of the Hospital Insurance Act*[26] specify that medical and hospital care granted to and received by First Nations within the Quebec network are funded by Régie de l'assurance maladie du Québec (RAMQ). RAMQ funds insured medical benefits,[27] i.e., medically necessary services provided by a doctor[28] for residents of Quebec.[29] According to Subsection 5(3) of the *Health Insurance Act*, Indians enrolled under the *Indian Act*[30] are considered residents of Quebec. Services delivered to First Nations in a hospital[31]are also funded by Quebec, just as they are for residents of Quebec.[32]

Regarding the organizational method for the health system, Section 100 of the *Act respecting health services and social services*[33] (hereinafter "LSSSS") establishes the fundamental principle of respect for the rights of users (culture, continuity of services, and access to necessary treatment) by health institutions.[34] This means that as residents

22 HEALTH CANADA, *op. cit.*, Note 15, p. 7.

23 *The Constitutional Act, 1867*, Subsections 92(7). 92(13, and 92(16).

24 *Health Insurance Act*, CQLR, c. A-29, Sections 2 and 3.

25 *Hospital Insurance Act*, CQLR, c. A-28, Paragraph 1(c) and Section 2.

26 *Regulation respecting the application of the Hospital Insurance Act*, CQLR, c. A-28, r. 1., Paragraphs 1(a) and (c), Sections 2 and 3.

27 *Health Insurance Act*, Paragraph 1*(a)*.

28 *Ibid.*, Section 3: "The cost of the following services rendered by a professional in the field of health are assumed by the Board on behalf of every insured person [...]."

29 *Ibid.*, Paragraph 1g.1).

30 *Indian Act*, RSC, 1985, c. I-5.

31 *Hospital Insurance Act*, Section 2 and Paragraph 31*(d)*. *Regulation respecting the application of the Hospital Insurance Act*, Paragraph 1*c)*. *Hospital Insurance Act*, Paragraph 1*c)*, Sections 2 and 3.

32 *Regulation respecting the application of the Hospital Insurance Act*, Paragraph 1*(m)* and Section 2.

33 *Act respecting health services and social services*, CQLR, c. S-4.2, Section 100: "The function of institutions is to ensure the provision of safe, continuous and accessible quality health or social services which respect the rights and spiritual needs of individuals and which aim at reducing or solving health and welfare problems and responding to the needs of the various population groups. To that end, institutions must manage their human, material, information, technological and financial resources effectively and efficiently and cooperate with other key players, including community organizations, to act on health and social determinants and improve the supply of services to the public. In addition, a local authority must elicit and facilitate such cooperation." In practice, this general provision does not seem feasible, as we will see in Chapter II (*Supra*,p. 27 et seq.).

34 *Ibid.*, Sections 2, 3, and 5.

of Quebec, members of First Nations can expect their spiritual needs to be met when receiving care under the provincial health system. FNQLHSSC highlights the lack of access and respect for culture in health services provided to First Nations.[35] This provision also adds that health facilities must "cooperate with other key players, including community organizations, to act on health and social determinants and improve the supply of services to the public."[36] To this end, an institution must "ensure that its services are provided **in continuity and complementarity with those provided by the other institutions** and resources of the region, and that such services are organized in a way that reflects the needs of the population it serves" (underlining ours).[37] Therefore, collaborative ties between health institutions and First Nations should be in place.[38]

To sum up, provincial laws grant powers for taking action on health to the provincial government. Quebec First Nations can nonetheless ask institutions to cooperate with healthcare providers in their region, under Section 100 of the LSSSS. However, the autonomy granted is minimal. This is the legal framework surrounding the 1983 ministerial principles (Subsection 1.1.2).

1.1.2
1983 Ministerial Principles

In 1983, the Quebec Cabinet adopted 15 principles[39] as the basis for government action involving First Nations. One of the principles specified that "aboriginal nations have the right to have and control, within the framework of agreements between them and the government, such institutions as may correspond to their needs **in matters of** (...) **health.**" (underlining ours).[40]

Two years later, in 1985, the Quebec National Assembly adopted the *Resolution on the Recognition of Aboriginal People's Rights*.[41] According to the resolution, the Quebec government must enter into agreements with First Nations who wish to do so to ensure they can exercise the autonomy provided for in the 15 principles.

35 First Nations of Quebec and Labrador Health and Social Services Commission, *op. cit.*, Note 10, p. 93.

36 *Ibid.*

37 *Act respecting health services and social services*, Section 101.

38 In our discussions with Quebec First Nations, we discovered that this does not appear to be the case in practice. This observation is supported in Chapter II. *Infra*, p. 27 et seq.

39 CABINET OF THE GOVERNMENT OF QUEBEC, *Quinze principes*, Québec City, 1983. For example, in the first principle, "Quebec recognizes that the aboriginal peoples of Quebec constitute distinct nations, entitled to their own culture, language, traditions and customs, as well as having the right to determine, by themselves, the development of their own identity." The document also states that "the aboriginal nations have the right, within the framework of existing legislation, to govern themselves on the lands allocated to them" but in addition that "the aboriginal nations have the right to have and control, within the framework of agreements between them and the government, such institutions as may correspond to their needs in matters of culture, education, language, health and social services as well as economic development."

40 *Ibid.*

41 QUÉBEC NATIONAL ASSEMBLY, *op. cit.*, Note 5.

In 1998, the Government of Quebec announced new guidelines for First Nations affairs, the three objectives of which are to develop "harmonious relations based on mutual trust and respect between aboriginal and non-aboriginal people, more self-government and increased financial self-sufficiency of aboriginal people."[42]

Based on this regulatory and political framework, the Government of Quebec made it possible for First Nations to enter into agreements governing accountability and development, under which they would be granted greater autonomy.[43] Such agreements may open the door to broader decision making, particularly for health (because the regulatory and political framework is not specific to health).[44] The agreements allow First Nations to have greater control over health services while ensuring the continuity and complementarity of second- and third-line care within the Quebec network.[45] However, the April, 1984 Quebec-Kahnawake agreement[46] is the only one entered into to date. It was signed between the Government of Quebec and the Kahnawake Mohawk Band Council and authorizes the Council to build and operate a hospital within its territory.[47] In addition, the hospital management authorities are not subject to the Quebec health system governance model, unlike the other institutions in the Quebec network. The Kahnawake Mohawk Band Council is in direct contact with Quebec's Ministère de la Santé et des Services sociaux.[48] Funds for building and operating the hospital are however under the control of the Government of Quebec.[49] The agreement was implemented thanks to a special law adopted in 1984, the *Act to ratify the Agreement concerning the building and operating of a hospital centre in the Kahnawake Territory*.[50] Under the *Act*, the Kahnawake hospital is a private institution under agreement, meaning that funding comes from the provincial government while management is by the individuals who own it.[51]

42 MINISTÈRE DU CONSEIL EXÉCUTIF, SECRÉTARIAT AUX AFFAIRES AUTOCHTONES, *The Quebec Government Proposes New Guidelines for Aboriginal Affairs*, Press release, Québec City, April 2, 1998, online: <http://www.autochtones.gouv.qc.ca/centre_de_presse/communiques/1998/saa_com19980402_en.htm> (consulted April 8, 2015).

43 QUÉBEC MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, Note 6, p. 7.

44 *Ibid.*

45 *Ibid.*, p. 6.

46 Although this agreement was entered into before the *Resolution on the Recognition of Aboriginal People's Rights* was adopted by the National Assembly, it reflects the spirit of the 15 principles drawn up by Cabinet in 1983.

47 *Act to ratify the Agreement concerning the building and operating of a hospital centre in the Kahnawake Territory*, RSQ, c. 13.

48 Jacques-Yvan Morin, "René Lévesque et les droits fondamentaux des autochtones du Québec," online: <http://fondationrene-levesque.org/rene-levesque/ecrits-sur-rene-levesque/jacques-yvan-morin-rene-levesque-et-les-droits-fondamentaux-des-autochtones-du-quebec/> (website consulted September 10, 2014).

49 *Act to ratify the Agreement concerning the building and operating of a hospital centre in the Kahnawake Territory*, Section 2.

50 *Ibid.*

51 *Ibid.*, Section 4.

Overall, such agreements originating from the *Resolution on the Recognition of Aboriginal People's Rights* adopted by the National Assembly only grant powers to act with respect to the management of health services and not, for example, the power to legislate on health, which thus limits First Nations' degree of autonomy. We will see that such power was granted through a recent agreement in the Yukon.

Current Quebec law allows Quebec First Nations to participate in the governance of health programs within health institutions. Autonomous powers to act on health can be acquired upon signing an accountability and development agreement with the provincial government. The possibility of acquiring some degree of self-determination therefore remains minimal, overall. We will see that federal laws supplement this legal framework by offering additional options for granting powers to act on health (Section 2).

1.2 COMPLEMENTARITY OFFERED BY FEDERAL LAWS

The goal of this section is to present and analyze the federal laws (Subsection 1.2.1) and agreements that can be entered into (Subsections 1.2.2 and 1.2.3) so that First Nations can enjoy autonomous powers to act on health.

1.2.1 Scope and Limitations of Federal Laws

Under Subsection 91(24) of the *Constitutional Act, 1867*,[52] the Federal Parliament initially had jurisdiction over "Indians, and Lands reserved for the Indians." This meant the Federal Parliament was assigned responsibility for the administration, provision, and funding of health services on reserves for First Nations (or non-agreement Nations)[53]. This prerogative also allowed the Parliament to adopt legislation on health for First Nations.[54]

It also allowed the Federal Parliament to adopt the first *Indian Act* in 1876. This *Act* covered many aspects of First Nations life, including "band membership, the organization and exercise of band government, and by-laws."[55] Under Paragraph 81(1)(a) of the *Indian Act*, band councils were able to make by-laws, for example, "to provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases."[56] Such by-laws *came* into force within forty days of being sent to the Minister

52 *Constitutional Act, 1867*, Subsection 91(24).

53 QUÉBEC MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, *Note 6, p. 6. However, medical care is funded by Régie de l'assurance maladie du Québec. Specialized and subspecialized care are paid for by the Quebec network. However, Nations can opt to fund these services through contribution agreements or payment transfers. Ibid.*, p. 6 and 7. See also the Health Canada website: <www.hc.sc.gc.ca>.

54 This power allowed the government of Canada to create the Non-insured Health Benefits Program (NIHBP) for Canadian First Nations, providing coverage for health services not insured by provinces and territories.

55 LIBRARY OF PARLIAMENT, SOCIAL, HEALTH AND CULTURAL AFFAIRS SECTION, *Primer on Aboriginal Issues* by Tonina Simeone, Ottawa, 2011, p. 8, online: <http://carolynbennett.ca/files/2010/07/Primer-on-Aboriginal-Issues_EN.pdf> (consulted April 8, 2015).

56 *Indian Act*, Paragraph 81(1)(a).

for Indigenous and Northern Affairs Canada (formerly Indian and Northern Affairs Canada, then Indigenous and Northern Affairs Canada).[57] Unless disallowed by the minister within that period, the by-law took effect,[58] with the same legal effect as a federal government regulation.[59]

However, in practice this power granted to band councils to make health by-laws is limited in its scope and effect on matters that can be governed by a federal regulation. Such power is concurrent with the federal government's power to issue regulations on similar matters, i.e., the transmission of infectious or contagious diseases on reserves,[60] medical treatment and health services for First Nations,[61] and hospitalization and mandatory treatment for members of First Nations suffering from infectious diseases[62] (see Table 2). In accordance with Subsection 81(1) of the *Indian Act*, by-laws issued by band councils must be consistent with the *Act* or the regulations made by the federal government. In addition, Section 4 of the same *Act* prevents the adoption of regulations that are incompatible with territorial and provincial laws on health and requires instead that First Nations comply with such territorial and provincial laws.[63] Although Quebec First Nations have power to make regulations on health through band councils, such power is limited both in terms of the topics that can be regulated and by legislation introduced at the provincial and federal levels.

Table 2: Topics that can be governed by by-laws or federal regulations

By-laws issued by band councils Subsection 81(1) of the *Indian Act*	**Federal government regulations Subsection 73(1) of the *Indian Act***
Adoption of measures relating to the health of reserve residents	Control of infectious, contagious, or other diseases on reserves
Precautions to take against the spread of contagious and infectious diseases	Medical treatments and health services for Indians
	Hospitalization and mandatory treatment of Indians suffering from infectious diseases

57 *Ibid.*, Subsection 82(2).

58 *Statutory Instruments Act*, RSC, 1985, c. S-22, Subsection 2(1).

59 *Red Bank First Nation*, (1999) CCRI no. 5.

60 *Indian Act*, Paragraph 73(1)f).

61 *Ibid.*, Paragraph 73(1)*g)*.

62 *Ibid.*, Paragraph 73(1)*h)*.

63 NATIONAL COLLABORATING CENTRE FOR ABORIGINAL HEALTH, *Looking for Aboriginal Health in Legislation and Policies, 1970–2008: The Policy Synthesis Project*, 2011, p. 27, online: <http://www.nccah-ccnsa.ca/docs/Looking%20for%20Aboriginal%20Health%20in%20Legislation%20and%20Policies%20-%20June%202011.pdf>.

Later, in 1973, the federal government adopted the *Comprehensive Land Claims Policy*[64] to clarify the negotiating terms for land claims by Canadian First Nations.[65] Thanks to this policy and Section 35 of the *Constitution Act, 1982* on which it is based,[66] an agreement between a Quebec community, the federal government, and a provincial government can be signed to create an aboriginal government that maintains a relationship of equals with the provincial and federal governments.[67] The signing of the *James Bay and Northern Quebec Agreement*[68] (hereinafter the "Agreement") is one such example. The Agreement reorganizes the territory of James Bay and Northern Quebec, establishing new administrative bodies with general and sometimes specific powers over the territory[69] while simplifying the legal context.[70] Municipalities then formed public corporations with local matters being administered and managed by a council.[71] Such municipalities are free to manage their internal affairs according to their customs while maintaining a connection to the Government of Quebec, which allows the population of Quebec to benefit from its involvement in the territory.[72] The impact of this health governance is examined in the third chapter. Here it is important to understand that thanks to Section 35 of the *Constitution Act, 1982* and the resulting policy, a Quebec First Nation can sign an agreement with the federal government (and a provincial government) to create its own government with greater autonomy, particularly in health.

The federal legislative framework makes it possible to grant First Nations an initial degree of autonomy for health. On the one hand, the Indian Act, adopted by the Federal Parliament under its constitutional jurisdiction, grants band councils regulatory power for health, although such power is substantially limited in practice. On the other hand, under Section 35 of the *Constitutional Act, 1867* and the resulting federal policy, First Nations can claim aboriginal rights by entering into agreements. These agreements may be the start of

64 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Comprehensive Land Claims Policy*, Ottawa, 1973.

65 Policy renewed in 1986 and currently under revision: INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Renewing the Comprehensive Land Claims Policy: Towards a Framework for Addressing Section 35 Aboriginal Rights*, Ottawa, September 2014, online: ‹https://www.aadnc-aandc.gc.ca/eng/1408631807053/1408631881247#chp3› (consulted April 8, 2015).

66 This section recognizes and affirms the aboriginal rights of the aboriginal peoples of Canada.

67 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *General Briefing Note on Canada's Self-government and Comprehensive Land Claims Policies and the Status of Negotiations*, Ottawa, 2013, online: ‹https://www.aadnc-aandc.gc.ca/eng/1373385502190/1373385561540›. While this is not the case for the Cree Agreement, a comprehensive land claims agreement can cover arrangements for self-government. INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Self-Government*, online: ‹https://www.aadnc-aandc.gc.ca/eng/1100100032275/1100100032276› (website consulted July 29, 2014).

68 *James Bay and Northern Quebec Agreement*, 1975. *Act approving the Agreement concerning James Bay and Northern Quebec*, CQLR, c. C-67. The following are signatories to the Agreement: the Quebec government, James Bay Energy Corporation, Société de développement de la Baie-James, Hydro-Québec, and the Quebec Grand Council of the Crees, James Bay Crees, Northern Quebec Inuit Association, Quebec Inuit, Port Burwell Inuit, and the Canadian government.

69 Sections 9 to 11 of the Agreement provide for the creation of local Cree governments, the Cree Regional Authority, the James Bay Regional Zone Council, as well as special entities, particularly for health. See on this topic: Ghislain Otis and Geneviève Motard, "De Westphalie à Waswanipi : la personnalité des lois dans la nouvelle gouvernance crie," *Les Cahiers de droit 50*, 1, 2009, p. 121, online: ‹http://www.erudit.org/revue/cd/2009/v50/n1/037739ar.pdf›.

70 *James Bay and Northern Quebec Agreement*, *op. cit.*, Note 68, p. xii.

71 *Ibid.*, p. xvi.

72 *Ibid.*, p. xix. Crees must allow access to Quebec public services such as health, police, and education.

negotiations with the federal government (and the provincial government). As we will see in the next subsection, the federal government has adopted various policies allowing First Nations to acquire additional powers to act (Subsection 1.2.2).

1.2.2
Scope and Limitations of Transfer Agreements

In 1980, an initial report, the Report of the Advisory Committee on Indian and Inuit Health Consultation[73] (hereinafter the "Berger Report"), recommended increased First Nation participation in the management, consultation, and control of community health care.[74] Then in 1983 a second report, the Report of the Special Committee on Indian Self-Government[75] (hereinafter the "Penner Report"), went further by recommending increased First Nation autonomy in the control of health services through a new relationship with Nations, based on autonomy. This set the scene for a major federal government policy to be drawn up, namely, the *1989 Health Transfer Policy* (hereinafter the "1989 Policy"), which still applies today to Canada's First Nations.[76]

The goal of the 1989 Policy was to transfer administration of health services for First Nations, managed in theory by Health Canada, to the Nations that wanted to administer them. In other words, the purpose of the Policy was to delegate management of health services to First Nations and to increase First Nation control over their own health programs. The Policy was based on numerous administrative documents, including the *Indian Health Policy 1979*[77] (hereinafter the "1979 Policy"), the goal of which was to "achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves."[78] This former policy was based on three pillars, namely:

1. Improving the health of First Nations using means implemented by the Nations themselves
2. Strengthening ties of trust between First Nations, the provincial government, and the federal government
3. Increasing the ability of First Nations to participate in decisions about their health[79]

The 1979 Policy already recognized that First Nations could administer their own community health programs.

73 HEALTH CANADA, *Report of the Advisory Committee on Indian and Inuit Health Consultation*, Ottawa, 1980.

74 HEALTH CANADA, *Ten Years of Health Transfer First Nation and Inuit Control*, online: <http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/10_years_ans_trans/index-eng.php> (website consulted July 16, 2014).

75 SPECIAL COMMITTEE ON INDIAN SELF-GOVERNMENT, *Indian Self-Government in Canada: Report of the Special Committee*, Ottawa, 1983.

76 HEALTH CANADA, *First Nations and Inuit Health Transfer Policy*, Ottawa, 1989.

77 HEALTH CANADA, *Indian Health Policy 1979*, online: <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php> (consulted April 8, 2015).

78 *Ibid.*

79 *Ibid.*

It is interesting to note that both federal policies (1979 and 1989) are administrative documents that, unlike legislative documents, have no binding legal effect. They are considered soft-law documents. However, they can grant rights or powers to contracting parties. Therefore these federal policies encourage the transfer of responsibility for healthcare management to First Nations that wish to take that responsibility, but they cannot require the government to make the transfer.

In practice, First Nations in favour of such a transfer must enter into negotiations with Health Canada.[80] Once the agreement has been signed, the community receives federal funding to manage health services and create new programs.[81] These agreements are called "contribution agreements"[82] or "transfer payments."[83] Of course, funding from Health Canada is conditional on compliance with the contractually binding conditions of the agreement. In this way, the federal government to some extent dictates the degree of flexibility in the allocation of funds, which can somewhat limit the ability of First Nations to act autonomously. Due to the specific characteristics of each Nation, the agreements vary according to the "level of control, flexibility, authority, reporting requirements and accountability."[84]

In addition, transfer payments are classified according to the funding model chosen by Health Canada (Table 3) out of the three options: set funding model, flexible funding model, and block funding model.

- Under a set funding model, Health Canada can grant a predetermined amount for a three-year period and create programs for First Nations in advance.[85] However, upon approval from the federal minister of health, the Nations will be able to modify the activities of such programs in exchange for writing preliminary and end-of-year reports for Health Canada.[86]
- The flexible funding model is a contribution agreement lasting two to five years under which First Nations must establish a health management structure for their territory as part of a multi-year work plan.[87] This model provides more flexibility than the first in terms of allocating funds, in particular the ability to carry funds forward as long as they are used for the same program.[88] Reports are also required for this model.

80 HEALTH CANADA, *op. cit.*, Note 76.

81 *Ibid.*

82 HEALTH CANADA, *Contribution Agreements*, online: <http://www.hc-sc.gc.ca/fniah-spnia/finance/agree-accord/index-eng.php> (consulted April 8, 2015).

83 *Ibid.*

84 *Ibid.*

85 *Ibid.*

86 *Ibid.*

87 *Ibid.*

88 *Ibid.*

- The contribution agreement can also be based on a block funding model, lasting five to ten years, under which First Nations determine their own health priorities and establish their own health service management.[89] This gives them more freedom in allocating resources while having the option to reinvest additional funds according to their health priorities.[90] First Nations are held accountable to Health Canada in the form of end-of-year audit reports and assessment reports every five years.[91]

At Health Canada's discretion, the different models can be combined to provide funding for numerous federal programs under the national funding model.[92] However, Nations are rarely able to choose the funding model(s) themselves.

Table 3: Types of Contribution Agreements According to Funding Model

	Set funding model	Flexible funding model	Block funding model
Duration	3 years	2 to 5 years	5 to 10 years
Powers	Modification of activities of programs established by Health Canada (with approval from the federal health minister)	Creation of a governance and fund allocation structure	Determination of health priorities, health services management, allocation of financial resources
Self-government	**Limited:** Preliminary and end-of-year reports required	**Limited:** Multi-year work plan and accountability	**Limited:** End-of-year audit reports and assessment reports

Notwithstanding the funding model chosen, powers to administer and create health programs and the power to manage funds allocated by the federal government are not autonomous powers. First Nations do indeed have more control over the health services provided for them, but the federal government holds them accountable for such control. The result is a delegation of powers rather than a meaningful transfer of responsibility for health to First Nations. The self-government agreement, discussed in the next subsection, is the most advanced form of agreement in this regard (Subsection 1.2.3).

1.2.3
Scope and Limitations of Self-Government Agreements

To address the lack of autonomy granted to First Nations under the 1989 Policy, in 1995 the Ministry of Indigenous and Northern Affairs Canada, on behalf of the Canadian government, drew up the *Inherent Right of Self-Government Policy*.[93] Under this policy, Nations subject to the Indian Act and settled on a reserve could acquire a greater degree

89 *Ibid.*
90 *Ibid.*
91 *Ibid.*
92 *Ibid.*
93 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Inherent Right of Self-Government Policy*, Ottawa, 1995.

of self-government by signing self-government agreements.[94] Such agreements grant First Nations (1) the "authority to act in a number of areas,"[95] including health, as well as (2) the power to pass laws in a number of areas of expertise,[96] particularly health, (3) while limiting the application of the *Indian Act*. They can cover various topics, such as the structure and accountability of First Nation governments, legislative powers, financial agreements and responsibilities for community programs and services.[97] Compared to transfer agreements, self-government agreements can give a community more control over the health of its members.

Self-government agreements can be implemented in various ways, such as in a treaty or contract, through legislation, or in a memorandum of understanding.[98] However, these various methods do not have the same legal effect. Treaties are constitutionally protected under Section 35 of the *Constitution Act, 1982*,[99] while contracts are legally protected under common contract law. Depending on the method that is used, the responsibility incumbent on the parties in complying with the signed document will vary.

Here too, case-by-case analysis is required to determine precisely which powers to act are granted under a specific self-government agreement and identify the agreement's scope and legal protection. To date, Canada has negotiated 21 self-government agreements, 18 of which are part of a modern treaty (also known as a comprehensive land claim agreement, discussed above).[100] In Quebec in 2004, the Mamuitun and Nutashkuan First Nations entered into an agreement-in-principle of general nature[101] with the provincial and federal governments, with a view to adopting a self-government agreement at a later time. Such an agreement would give Innu governments general power to adopt laws and regulations for their territory. Furthermore, under Paragraphs 8.4.4.1x) and 8.4.4.1xi) of the agreement-in-principle, Innu laws would prevail over any other law regarding health entities and traditional medicine.[102] It appears that the agreement-in-principle is part of a comprehensive land claim agreement under Section 35 of the *Constitution Act, 1982*[103]

94 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Resolving Aboriginal Claims - A Practical Guide to Canadian Experiences*, Ottawa, 2003, p. 32, online: <http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/rul_1100100014175_eng.pdf>.

95 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *The Government of Canada's Approach to Implementation of the Inherent Right and the Negotiation of Aboriginal Self-Government*, online: <https://www.aadnc-aandc.gc.ca/eng/1100100031843/1100100031844> (website consulted July 10, 2014).

96 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Fact Sheet: Aboriginal Self-Government*, online: <https://www.aadnc-aandc.gc.ca/eng/1100100016293/1100100016294> (website consulted July 10, 2014).

97 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Self-Government*, online: <https://www.aadnc-aandc.gc.ca/eng/1100100032275/1100100032276> (website consulted July 29, 2014).

98 *Ibid.*

99 *The James Bay and Northern Quebec Agreement* is one example. See *Infra*, p. 45 et seq.

100 See the Indigenous and Northern Affairs website: <http://www.aadnc-aandc.gc.ca/>.

101 FIRST NATIONS OF MAMUITUN AND NUTASHKUAN and the GOVERNMENT OF QUEBEC and the GOVERNMENT OF CANADA, *Agreement-in-Principle of General Nature*, March 31, 2004.

102 *Ibid.*, Paragraphs 8.4.4.1x) and 8.4.4.1xi).

103 *Constitution Act, 1982*, Schedule B to the *Canada Act 1982* (UK), 1982, c. 11, Section 35.

and the *1973 Policy on Comprehensive Land Claims*.[104] If the agreement is adopted, it will benefit from the constitutional protection that recognizes the aboriginal rights of First Nations. Such a land claim agreement was signed by the Cree in 1975 and, as stated above, the signed James Bay and Northern Quebec Agreement is a modern treaty and will be discussed in Chapter 3 of our report.

Land claim agreements (or modern treaties) governed by the *1973 Policy on Comprehensive Land Claims* [105]also result in the creation of an aboriginal government that maintains a relationship of equals with the provincial and federal governments.[106] Furthermore, comprehensive land claim regulations may cover self-government methods.[107]

In short, federal regulations include numerous policies that encourage First Nations to enter into agreements granting a varying degree of authority to act in health matters. Self-government agreements provide First Nations with the greatest powers because they grant the authority to pass laws on health. They also allow the signatory band council to issue regulations on health, management, and the creation of programs on health and managing financial resources. Health service transfer agreements grant First Nations the power to manage and create health programs as well as the power to manage funds allocated by Health Canada. However, the power to manage such funds is subject to an accountability requirement imposed by the federal government. Not all First Nations have signed such agreements. There is an obvious need to establish a governance model applicable to all. Finally, this prescriptive framework also gives band councils the power to make health regulations under Paragraph 81(1)(a) of the *Indian Act*. As mentioned above, however, this power is concurrent with the federal government's power to issue regulations on the same topics.

CONCLUSION

For our conclusion we will be comparing the legal origin, nature, scope, and limitations of powers currently available to Quebec First Nations for acting on health (see Table 4). Certain powers stem from legislation, others from agreements signed under ministerial policies. It is important to fully understand the difference because their legal effect and implementation methods will not be the same.

First of all, we have seen that legislation grants fixed powers that can be implemented automatically by First Nations. This is how the *Indian Act* allows band councils to issue by-laws on certain health-related matters. Once adopted by the Minister for Indigenous

104 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *op. cit.*, Note 65.
105 *Ibid.*
106 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *op. cit.*, Note 67.
107 INDIGENOUS AND NORTHERN AFFAIRS CANADA, *op. cit.*, Note 97.

and Northern Affairs, such regulations have the force of a statutory instrument. Despite the limitations of this power to act on health, it is easy for First Nations to use it as no additional steps are required.

Secondly, the law establishes government powers and the framework for exercising such powers while agreements must be entered into within the scope of these powers. Under the principle of prevailing law, legislation takes precedence over policy decisions made by the government: "the government may not, by agreement or contract, undertake not to exercise its powers."[108] In other words, agreements entered into under the *Health Services Transfer Policy, the Quebec National Assembly's Resolution on the Recognition of Aboriginal People's Rights*, and the *Midwifery Act* must comply with the provisions of federal and provincial legislation on health. This means there is little leeway in the scope of powers to act on health that may be delegated to First Nations. Such powers will mostly involve managing, creating, and administering health programs or managing financial resources. This legal constraint is certainly important in deciding which avenue to take for First Nations governance of health services.

Looking at it another way, entering into an agreement is certainly a more laborious and burdensome task than implementing a law. The time required for negotiation, the availability of the ministers involved, and the many steps in the process of adopting an agreement make this legal avenue the more difficult choice. On the other hand, negotiating the provisions of an agreement allows First Nations to have a meaningful discussion about self-government. In the end, agreements grant First Nations the power to manage, create, and administer health programs as well as the power to administer financial resources.

Self-government agreements have a specific status in terms of legal force and implementation. As mentioned above, such agreements may be implemented under laws, agreements, or modern treaties. The effects listed above apply to the implementation of self-government agreements under laws or agreements. Self-government agreements are different because they can be entered into in connection with a comprehensive land claim agreement or a modern treaty. When a self-government agreement is part of a comprehensive land claim agreement, it has the constitutional protection of Section 35 of the *Constitution Act, 1982*. In this case, the *Indian Act* does not apply to the territory affected by the self-government agreement, given the supremacy of constitutional legislation.

108 Henri Brun, Guy Tremblay, and Eugénie Brouillet, *Droit constitutionnel*, 5th ed., Éditions Yvon Blais, Cowansville, 2008, p. 699.

Table 4: Summary of Quebec First Nations' Powers to Act on Health

	Band council's power to make regulations	Power to manage health programs and financial resources (federal)	Power to pass laws	Power to manage health programs (provincial)	Power to provide health services in accordance with traditions
Origin	Law	Policy and agreement	Policy and agreement	Resolution and agreement	Laws and agreement
Nature	Regulation	Management	Legislation and management	Management	Action
Scope	Concurrent and limited	Delegated and limited due to accountability	Full	Delegated	Limited
Topics	Adoption of measures relating to residents' health and precautions to take to fight the spread of contagious and infectious diseases	Management of health services, creation of programs, management of funds allocated	Health services	Health services	Procedures limited to midwives

The legal system governing health for Quebec First Nations is clearly complex. The Quebec and Canadian governments are open to First Nations participation in Quebec health services. Certain government laws and policies grant First Nations powers to act on health. Unfortunately, despite legislative tools currently available, our research has shown that self-government for First Nations, in terms of health, is still substantially limited.

2
OBSERVATIONS IN LIGHT OF LITERATURE AND CONSULTATIONS WITH FIRST NATIONS

INTRODUCTION

Chapter 2 of this report sets out the legislative framework First Nations can currently work within to improve their degree of self-government and governance relating to health. To identify and develop governance models that can be put in place within this framework, it is important to first pinpoint the problems with current governance. It has been harder than anticipated to identify these problems for the purpose of this report. For one thing, literature or publications on this topic are rare. In addition, due to time restraints we were not able to carry out an empirical study for each First Nation in Quebec. As a result, our observations are based on conversations with FNQLHSSC representatives and representatives of specific Nations suggested by FNQLHSSC.

This chapter presents our findings from these conversations. We will categorize the issues as social and organizational. In the third chapter we will assess the extent to which these problems can be resolved or minimized through new governance models that fall within the current legislative framework (described in Chapter 1). We can categorize our observations as follows:

1. Less than ideal cooperation between Nations and health institutions
   - Institutions failing to comply with the continuity of healthcare and services requirement
   - Limited access to collective prescriptions
   - Limited number of community representatives in health institutions outside the Nations
2. Health centre and band council have different health expertise and priorities
3. Inadequate citizen involvement

As stated previously, in Quebec Section 100 of the *Act respecting health services and social services* (hereinafter the *Act*) specifies that health institutions must cooperate with players from the communities they serve. Subsection 101(2) also states that institutions must "dispense the required health or social services directly, or have them provided by an institution, body or person with which or with whom it has entered into a service agreement under Section 108." Furthermore, Section 108 says that an "institution may enter into an agreement with another institution, a body or any other person for (...)

the provision on behalf of the institution of certain health services or social services required by a user of the institution." As we will see below, it appears that these legislative provisions are not always adequately applied for First Nations.

2.1 LESS THAN IDEAL COOPERATION BETWEEN NATIONS AND HEALTH INSTITUTIONS

During our conversations we noted a deficiency in post-hospitalization services, including respiratory therapy, offered within certain Nations. We were told that such services were not reimbursed or covered by the province of Quebec. We should point out that respiratory therapy is not covered by Quebec's health insurance scheme for any Quebec residents because services are not provided by a doctor.[109] However, when these services are offered at a hospital, they are covered by Quebec's hospital insurance scheme.[110] As for coverage when these services are provided as a continuation of hospital services received, we observed a certain regulatory vacuum. In our opinion, if these services are a continuation of hospital services and are not available at a local community service centre (e.g., CLSC), the associated costs should be charged to the health institution serving the community. The charge could be in the form of an agreement entered into under Section 108 of the *Act*.

In addition, we have observed that certain Nations have limited access to collective prescriptions. A collective prescription is a "a prescription given by a physician or a group of physicians to an authorized person, specifying the medications, treatments, examinations, or other forms of care to be provided to a group of persons or for clinical situations stipulated in this prescription, the circumstances in which they may be provided, and the possible contraindications."[111] As the Health and Welfare Commissioner notes in his report *Les médicaments d'ordonnance : état de la situation au Québec:* "Collective prescriptions allow certain health professionals to play a greater role in managing patients' medication therapy. These professionals can initiate treatment with medications when the clinical situation meets the criteria set out in the collective prescription (for example, hormonal contraception or nicotine replacement therapy), or administer or adjust doses of a current medication (for example, adjust a warfarin dose according to the results of an international normalized ratio [INR 16], used to assess the effectiveness of the anticoagulant treatment)."[112]

Given that health professionals are responsible for ensuring consistent health services are provided in non-agreement Nations, it is extremely helpful for them to be able to issue such prescriptions. Collective prescriptions are, however, subject to prior approval from

109 *Health Insurance Act*, Section 3

110 *Hospital Insurance Act*, Sections 2 and 3. *Regulation respecting the application of the Hospital Insurance Act*, Sections 1, 2, and 3.

111 *Règlement sur les normes relatives aux ordonnances faites par un médecin*, CQLR, c. M-9, r. 25-1, Subsection 2(2).

112 Health and Welfare Commissioner, *Les médicaments d'ordonnance : état de la situation au Québec*, Québec City, 2014, p. 16.

the Council of Physicians, Dentists and Pharmacists (CPDP).[113] During our meetings with Nations representatives, we found out that obtaining collective prescriptions can be a complex and lengthy process.

Following our interviews, we also found that a very limited number of community members sit on boards of directors of institutions[114] and on user committees.[115] This partly explains the difficulties in establishing and maintaining cooperation with a health institution that serves the community.

2.2 THE DIFFERENT HEALTH PRIORITIES OF HEALTH CENTRES AND BAND COUNCILS

Our meetings show that the limitations to current self-government for First Nations in making decisions about the provision health services are sometimes viewed differently by health centre representatives and band council representatives.

Firstly, all agree on the decision-making limitations imposed by the granting of federal transfers by program. The requirement to allocate certain amounts of money according to certain programs established by the federal government does not meet the needs of each community in all cases. Many feel that members of health centres and band councils are focusing more on determining the health priorities for their community. In addition, Bill No. 10,[116] recently adopted by the Quebec National Assembly and currently in force, specifies that health institutions must now manage their budgets by program-service, without being able to move funds between budgets unless special permission is given by the health minister. Institution managers and First Nation representatives have the same concerns about this change as they do about granting per-program budgets to band councils, namely, that the institutions know more about the health priorities and needs of their community than the minister does.

113 *Act respecting health services and social services, Section 213: "A council of physicians, dentists, and pharmacists shall be established for every institution which operates one or more centres in which not fewer than five physicians, dentists, or pharmacists are practising. The council shall be composed of all the physicians, dentists, and pharmacists practising in any centre operated by the institution."*

114 *An Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies*, QL, 2015, Chapter 1, Section 9 et seq., online: <http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/O-7.2>.

115 *Ibid.*

116 *Ibid.*

2.3
INADEQUATE CITIZEN INVOLVEMENT

Governance implies participation by many different stakeholders. Ideally, governance fosters citizen involvement to generate a sense of ownership and self-worth.[117] Regarding the provision of health services, such involvement can take the form of community members taking part in the health decision-making process and having a sense of contributing to better health for the community through personal responsibility.

From our meetings we learned that in some communities, citizen involvement in health governance is particularly weak. Community members' participation in the band council decision-making process for allocating health funds is sometimes virtually nonexistent, as is their participation on institution user committees.

CONCLUSION

Our observations about the limitations to autonomous decision making regarding health and about the quality of health governance by Quebec First Nations lead us to conclude that the situation can be improved within the current legislative framework, presented in Chapter 1. For this to happen, we believe First Nations should consider a variety of options.

As mentioned above, numerous options could improve local governance, namely: (1) Strengthening the relationship between Nations and the institutions that serve them, in particular through agreements and the participation of community representatives within such institutions (on the board of directors or user committee, for example); (2) Improving health management expertise among band councils through training by health centre managers or similar; (3) Increasing citizen participation in local decision making. To this end, a study of how health cooperatives operate, with citizen participation, would be helpful. We will include such a study in our final report.

These solutions are but a small step towards greater decision-making autonomy and improved health governance by First Nations. Nonetheless, we believe they should be taken into consideration, especially as they do not involve combining preferences among Nations (reconciliation of interests).

An even bigger step would make it possible to meet the needs of First Nations, but implies a reconciliation of interests between Nations and, in many cases, agreements with the federal and provincial governments. To identify potential options, we have studied certain initiatives carried out in Canada and elsewhere. These will be reviewed in the next chapter (Chapter 3).

117 José M. Ruano DE LA FUENTE, "La participation citoyenne comme source de légitimité de la gouvernance," *La Revue administrative*, 59, 353, September 2006, 487-495.

3
OPTIONS WITHIN THE CURRENT CONSTITUTIONAL LIMITATIONS

INTRODUCTION

First Nations health is a concern and self-government remains a major health determinant. Improved health governance, whether nationally or locally, has the potential to expand self-government within the current boundaries of the legislative framework presented in Chapter 1.

3.1
THE ORGANIZATIONAL AND CONTRACTUAL OUTLOOK BETWEEN NATIONS AND THE FEDERAL AND PROVINCIAL GOVERNMENTS

This section analyzes governance models that require a relatively long implementation process and a combining of preferences among First Nations. The examples are taken mostly from other Canadian provinces given that the constitutional framework is the same as that presented in the first chapter. Just one model is from another country (the Maori) due to the advantages the initiative offers. The following subsections analyze the various powers to act granted by legal norms and agreements governing these models, the scope and nature of the initiatives, and their applicability under Quebec law.

3.1.1
British Columbia

In 2011,[118] First Nations in British Columbia[119] adopted an innovative governance model based on an independent, not-for-profit aboriginal health authority, First Nations Health Authority, FNHA.[120] This model is not based on a self-government agreement,[121] but on a triple partnership agreement—the *British Columbia Tripartite Framework Agreement on First Nations Health Governance* (hereinafter "tripartite agreement"), signed by the

118 At that time First Nations in the province were facing two challenges: (1) Federal health services did not adequately reflect their priorities and (2) They were not receiving sufficient provincial health services.

119 To be able to create partnerships and with the support of the provincial government, leaders of British Columbia First Nations rallied around a political organization—the First Nations Health Council (FNHC). Strictly speaking, the council has no decision-making power for health. It is responsible for a) Supporting implementation of the Tripartite Change Accord, (b) Helping First Nations introduce health plans, (c) Advising the parties, and (d) Ensuring transparent governance for First Nations. The council represents First Nations, as its fifteen members include three for each of the five regions (Fraser, Interior, Northern, Vancouver Coastal, and Vancouver Island). Each of the three regional members is chosen from representatives of regional caucuses who are generally band chiefs. FIRST NATIONS HEALTH COUNCIL, *Together in Wellness*, 2011/2012 Annual Report, Vancouver, 2012, online: <http://www.fnhc.ca/pdf/together-in-wellness_2011-12_interim_report.pdf> (consulted April 8, 2015).

120 The parties had five years to create an independent, not-for-profit committee to represent Nations in the province. This committee is the FNHA, established under the *Society Act*, RSBC, c. 433, Section 7.1.

121 See self-government agreements: *supra*, p. 21.

Leadership Council[122] representing British Columbia First Nations, the provincial health minister, and the First Nations and Inuit Health Branch (FNIHB) of Health Canada at the federal level.[123]

The tripartite agreement includes in Appendix 1 a framework agreement, *Canada Funding*, which specifies that the FNHA identifies, funds, provides, and administers all health programs instead of the federal government's FNIHB. The framework agreement allows for the federal services budget to be transferred from FNIHB to the FNHA but only for a maximum of ten years.[124] The FNHA is also in charge of planning the construction of health infrastructure,[125] employment contracts,[126] managing contribution agreements with Nations,[127] and managing the confidentiality of information.[128]

122 The Leadership Council is made up of the First Nations Health Society and the First Nations Health Council. They both represent British Columbia First Nations.

123 HER MAJESTY IN RIGHT OF CANADA, HER MAJESTY IN RIGHT OF THE PROVINCE IN BRITISH COLUMBIA, FIRST NATIONS HEALTH AUTHORITY, and FIRST NATIONS HEALTH COUNCIL, *British Columbia Tripartite Framework Agreement on First Nations Health Governance*, October 13, 2011, online: <http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/tripartite/framework-accord-cadre-eng.php> (consulted February 5, 2015).

124 For a renewable period of ten years (ibid., CF.9b]), the agreement specifies the amounts of money transferred as well as a series of associated agreements relating to employees or health programs. In the agreement, the parties agree that the transfers will be effective no later than two years after the agreement was signed. As agreed, the effective transfer of responsibilities to FNIHB began on July 2, 2013, with the FNHA taking over the funding, administration, and development of health programs. The transfer was completed on October 1, 2013, with federal services being provided to the regions. BRITISH COLUMBIA ASSEMBLY OF FIRST NATIONS, *Governance Toolkit: A Guide to Nation Building, Part 1: The Governance Report*, 2nd edition, 2014, p. 8, online: <http://www.bcafn.ca/wp-content/uploads/2016/06/Governance-Toolkit.pdf> (consulted February 5, 2015).

125 This agreement is highly beneficial because it allows the FNHA, in cooperation with First Nations, to plan the construction of health infrastructure initially as part of a transition plan (*Interim Capital Plan*), then as a longer, five-year plan (*Multi-Year Capital Plan*). The funds transfer by Health Canada includes the budget for such an investment ($10,340,000 subject to a 5.5% increase per year). However, land remains Crown property and its use must be approved by the province.

126 The agreement provides for the gradual transfer of FNIHB employee contracts to the FNHA. For this to happen, the FNHA has sent reasonable, permanent full-time or part-time employment offers to employees. Once new employment contracts are signed, employees are funded by the FNHA and the British Columbia Labour Code applies. FIRST NATIONS HEALTH COUNCIL, *Tripartite Framework Agreement on First Nation Health Governance Sub-Agreement Summary*, 2012, p. 6 and 10, online: <http://www.fnhc.ca/pdf/APP_C_Summaries-FIN.pdf> (consulted February 5, 2015). Most FNIHB employees accepted the offer from FNHA. To replace those who did not, the FNHA implemented a recruitment campaign. Conference call lasting one hour and 15 minutes with James Rankin, M.P.H, Regional Health Liaison, Vancouver Coastal, January 15, 2014.

127 These are tripartite agreements in force since October 1, 2013, signed by the FNHA, a community, and the community's region. They simply replace the Health Canada agreements according to the same terms and conditions. HER MAJESTY IN RIGHT OF CANADA, *op. cit.*, Note 123, Appendix 5 (7). The community must willingly comply. To our knowledge, only two Nations have refused. Conference call lasting one hour and 15 minutes with James Rankin, M.P.H, Regional Health Liaison, Vancouver Coastal, January 15, 2014. If the agreements are not signed, the FNHA provides replacement funding under the same terms and conditions as funding for the Health Canada Contribution Agreement. Nations therefore do not have a choice. FIRST NATIONS AND INUIT HEALTH BRANCH, *Contribution Agreements*, online: <http://www.hc-sc.gc.ca/fniah-spnia/finance/agree-accord/index-eng.php> (consulted February 5, 2015). However, a community participation process must take place before far-reaching changes are made to the current contribution agreements, according to the Nations' wishes. FIRST NATIONS HEALTH AUTHORITY, Consensus Paper, Vancouver, 2011, p. 9, Directive 6, online: <http://www.fnhc.ca/pdf/Consensus_Paper-_BC_First_Nations_perspectives_on_a_new_Health_Governance_Arrangement-_FIN.pdf> (consulted February 5, 2015).

However, the tripartite agreement specifies that services provided and financed[129] by the Government of British Columbia under the *Medicare Protection Act*[130] remain the responsibility of the province through its health authority, made up of the Provincial Health Services Authority (PHSA) and five Regional Health Authorities.[131] In this tripartite agreement, however, the provincial government undertakes to (1) provide more health services to First Nations and (2) plan and manage such services specifically in accordance with First Nations' priorities. To determine such priorities, each of the five Regional Health Authorities must sign a partnership agreement (Health Partnership) with First Nations leaders in each region ("caucus") and the FNHA, which is also represented by its regional committee. The agreements also provide for the development of a regional health plan that must include these priorities.[132] Then, when the regional health objectives have been reached, the parties are expected to sign a new agreement specifying new priorities.[133] Nations in the same region may have different priorities. This is why Nations can share their specific needs with the FNHA subregional committees. Next, the subregional committees report these needs to the FNHA regional committees, where they are taken into account in the regional health plans.[134] The regional committees also send their report on priorities to the FNHA, which will consolidate priorities from all Nations in all regions in drawing up its multi-year health plan.

128 In this agreement, the parties undertake to uphold the confidentiality of First Nations information throughout the process of transferring data from the parties to the FNHA for the new governance method. Furthermore, on April 16, 2010, the same parties had signed the *Tripartite Data Quality Sharing Agreement* (FIRST NATIONS HEALTH COUNCIL, *First Nations in B.C. Tripartite Data Quality and Sharing Agreement, Vancouver, February 16, 2010, online: <http://www.fnhc.ca/pdf/BC_Tripartite_Data_Quality_and_Sharing_Agreement_-_SIGNED_COPY.pdf> (consulted February 5, 2015) which provides for the creation of a client file for First Nations members, allowing parties to the tripartite agreement and external researchers to access data on First Nations. HEALTH COUNCIL CANADA, Jurisdictional profiles on health care renewal: An appendix to Progress Report 2013 – British Columbia*, Vancouver, 2013. p. 7, online: <http://conseilcanadiendelasante.ca/n3w11n3/progress2013/BritishColumbia2013_EN.pdf> (consulted February 5, 2015).

129 These are all the services covered under hospital insurance and health insurance legislation. In practice, First Nations visit provincial health institutions when they live in urban environments.

130 *Medicare Protection Act*, RSBC 1996, c. 286. See also on this topic: BRITISH COLUMBIA ASSEMBLY OF FIRST NATIONS, *op. cit.*, Note 124. Josée G. Lavoie, "Policy and Practice Options for Equitable Access to Primary Healthcare for Indigenous Peoples in British Columbia and Norway," (2014) 5 *The International Indigenous Policy Journal* 5, 1, January 2014, p. 2, online: <http://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1160&context=iipj> (consulted February 5, 2015). In practice, provincial health services were used infrequently by Nations, except for Nations in urban environments such as the Vancouver and Vancouver Coastal regions.

131 HER MAJESTY IN RIGHT OF CANADA, *op. cit.*, Note 123.

132 All funding provided by the federal government to the provincial government must be used, as explained above.

133 As an example, the Vancouver Coastal regional health plan is expected to be ready for distribution in the coming weeks, resulting in a new agreement. Conference call lasting one hour and 15 minutes with James Rankin, M.P.H, Regional Health Liaison, Vancouver Coastal, January 15, 2014.

134 The partnership agreements summarize each region's health goals (3–4 pages at most) while the health plans are much more detailed (up to a hundred pages).

Table 5: Summary of the British Columbia Initiative

	Government of British Columbia: Provincial Health Authority and the Regional Health Authorities	FNHA	First Nations regional/ subregional committees	First Nations
Management	Management of provincial services	Management of federal government services		
Cooperation with First Nations	- Partnership agreement with First Nations regional committees - Regional health plans	- Multi-year health plan	- Regional health plans - Priorities report	- Needs and priorities sent to their subregional and regional committee

This British Columbia governance model created in 2011 is a first in Canada. For many people, it represents a major historic breakthrough capable of inspiring First Nations chiefs in other provinces.[135] This health governance model is based on seven directives,[136] all of which mention including First Nations as equal partners in decision-making processes, and thus pave the way for cooperation that Nations had not been able to enjoy up to now.[137] These directives are:[138]

1. ***"Community-driven, nation-based":***
   a. Governance must be exercised by the Nations, for the Nations
   b. Autonomy of First Nations must not be compromised
   c. All Nations must take part in the process
   d. Health programs and services must be the result of consultation with individuals from all Nations
   e. First Nations community health agreements and programs must be promoted and enhanced

135 Peter O'Neil, "B.C. First Nations take over their own health care services," *Vancouversun.com*, September 30, 2013, online: <http://www.vancouversun.com/health/First+Nations+take+over+their+health+care+services/8979530/story.html#__federated=1> (consulted February 5, 2015). BRITISH COLUMBIA FIRST NATIONS HEALTH AUTHORITY, BRITISH COLUMBIA MINISTRY OF HEALTH, HEALTH CANADA, One-year anniversary of the historic transfer of health services for BC First Nations, press release, October 1, 2014, online: <http://news.gc.ca/web/article-en.do?nid=889159&tp=1&_ga=1.147661748.222670126.1480693455> (consulted February 5, 2015).

136 FIRST NATIONS HEALTH AUTHORITY, *op. cit.*, Note 127.

137 Miranda D. Kelly, "Toward a New Era of Policy: Health Care Service Delivery to First Nations," *The International Indigenous Policy Journal* 2, 1, May 2011, online: <http://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1017&context=iipj> (consulted February 5, 2015).

138 FIRST NATIONS HEALTH AUTHORITY, *op. cit.*, Note 127, p. 8 and 9.

2. ***"Increase First Nations decision making and control":***
    a. Increase First Nations influence in health program and service philosophy, design, and delivery at the local, regional, provincial, national, and international levels
    b. Develop a wellness approach to health including prioritizing health promotion and disease and injury prevention
    c. Implement greater local control over community-level health services
    d. Involve First Nations in decision making about health at the provincial and federal levels
    e. Encourage the publication of First Nations health data
    f. Devolve the delivery of programs to local and regional levels as much as possible and when appropriate and feasible
3. ***"Improve services":***
    a. Protect, incorporate, and promote First Nations knowledge, beliefs, values, and practices into all health programs and services
    b. Improve and revitalize Non-Insured Health Benefits programs
    c. Make access to nurses and other health providers for primary care easier and faster
4. ***"Foster meaningful collaboration and partnership ":***
    a. Collaborate with other First Nations, governments, and more generally all citizens to address social, health, and environmental determinants of First Nations
    b. Enable relationship-building between First Nations and regional health authorities to align First Nations' needs and realities with provincial health plans
5. ***"Develop human and economic capacity":***
    a. Increase awareness among health professionals of First Nations' needs and values
    b. Hire more health workers
    c. Leverage additional funding from federal and provincial sources for First Nations in British Columbia to invest in infrastructure
6. ***"Be without prejudice to First Nations' interests":***
    a. Preserve the pre-existing rights of First Nations
    b. Abide by pre-existing agreements
    c. Ensure there is no impact on the fiduciary duty of the Crown

7. ***"Function at a high operational standard":***

   a. Ensure governance is highly prudent, well structured, and highly transparent, with clear and regular reporting

   b. Make best and prudent use of available resources

   c. Implement appropriate competencies for all those involved in governance (health workers and managers)

These directives call for First Nations to be actively involved in healthcare planning in their community via a decentralized system of cooperation between subregional and regional committees, provincial health authorities, and the FNHA (see Table 6).[139] Our research has however revealed five limitations to this model (see Table 6). First of all, like any other approach requiring communities to come together[140] and enter into an agreement at the federal and provincial levels, the time needed to put this governance model in place is substantial.[141] Moreover, the tripartite agreement is essentially based on trust[142] and is only protected in the form of a contract. A contract can be terminated[143] and therefore is not as secure as an act or treaty, for example. In addition, the transfer of responsibilities from the federal government to the FNHA is only valid for ten years and subject to the prudent use of financial resources,[144] meaning that the government still has some control over financial transfers and holds the FNHA accountable. The FNHA is therefore not fully autonomous.[145]

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139 In addition, 1) All employees must be trained on First Nations culture, 2) Band chiefs report the needs and priorities of their Nations to the FNHA regional and subregional committees, and 3) The FNHA is made up of independent administrators.

140 In the case of British Columbia, only two Nations refused to take part in this governance method. Email interview with Dr. Josée Lavoie, Director of Manitoba First Nations, Centre for Aboriginal Health Research and Associate Professor for Community Health Sciences at the University of Manitoba Faculty of Medicine.

141 Negotiations took almost ten years and once the tripartite agreement was signed, it took an additional four years for governance to be implemented.

142 Stefan Wilmot, "First Nations health care and the Canadian covenant," (2014) *Medicine, Health Care and Philosophy* 17, 1, February 2014, 61–69.

143 Sections 12.1 and 12.2 of the tripartite agreement specify that the parties intend the agreement to be long term but if one of the parties wishes to terminate the agreement, it may do so subject to 1) providing written notice of at least 18 months and 2) meeting with the other parties to find a compromise to continue with the current agreement. HER MAJESTY IN RIGHT OF CANADA, *op. cit.*, Note 123, Subsections 12.1 and 12.2.

144 The FNHA does not have a Treasury Board. Nonetheless its financial department must monitor its own financial capacity. The tripartite agreement states that the FNHA must prepare financial statements and a cash flow table each fiscal year. These reports must be audited by an independent British Columbia entity and then made available to the members, the parties (Health Canada and the Government of British Columbia), the Auditor General of Canada, and the Auditor General of British Columbia. HER MAJESTY IN RIGHT OF CANADA, *op. cit.*, Note 123, Paragraphs 42.2*(k)*, *(l)*, and *(m)*. They must also be made available to the public. Health plans—either the transition plan (Interim Health Plan) or the five-year plan (Multi-year Health Plan) depending on the FNHA's level of governance—must also be sent to the parties. These plans explain how FNHA funds are distributed. If the FNHA fails to meet one of its obligations, FNIHB can withhold payments to the FNHA by sending it a 30-day notice (FIRST NATIONS HEALTH COUNCIL, *Tripartite Framework Agreement on First Nation Health Governance Sub-Agreement Summary*, 2012, p. 6, online: <http://www.fnhc.ca/pdf/APP_C_Summaries-FIN.pdf> (consulted February 5, 2015). It is expressly specified that the Auditor General of Canada can at any time carry out a financial audit of FNHA performance in relation to the funds paid by Health Canada. HER MAJESTY IN RIGHT OF CANADA, op. cit., Note 123, Paragraph 4.2(2)(m). However, in the case of a natural disaster, the provincial and federal governments have agreed to help the FNHA financially. FIRST NATIONS HEALTH AUTHORITY, 2014-2015, the Year Ahead, 2014, online: <http://www.fnha.ca/newsContent/Documents/FNHA-Communique-2014-2015-the-year-ahead.pdf> (consulted February 5, 2015).

145 Paul Webster, "Local control over Aboriginal health care improves outcome, study indicates," (2009) 181 *Canadian Medical Association Journal*, 181, 11, November 24 2009, 249–250, online: <http://www.cmaj.ca/content/181/11/E249.full.pdf+html>.

Finally, the tripartite agreement limits Nations' ability to establish self-determination and thus limits their control over their own health system.[146] Questions about shared powers between the federal government and the provincial government are not necessarily resolved because each still has jurisdiction over health. During negotiations, Nations reportedly criticized the lack of clarity regarding the different roles assigned to the provincial and federal governments.[147] Furthermore, despite having begun to cooperate with the FNHA, the province alone is responsible for the services it chooses to provide. The problem is that remote Nations find it difficult to access provincial infrastructure. This would imply a need for more funding from the provincial government. As already mentioned, the province is focusing more on urban regions where provincial infrastructure is already in place. In addition, recourse to provincial services effectively implies that First Nations' practices are not being observed, which creates a cultural problem for many Nations.[148]

Table 6: Pros and Cons of the British Columbia Initiative

Pros	Cons
Cooperation among all partners	Long time to put in place (about ten years)
Consideration of First Nations' priorities in various health plans	Requirement for all First Nations and governments to be onboard
Important role of regional and subregional committees	Power delegated to agency that is not represented by chiefs
Willingness to bring employees and Nations closer together (forums, cultural training, and so on)	Provincial services remain the responsibility of the provincial health ministry

146 Alexandra J. M. Kent, "Restructuring First Nations Health Governance: A Multilevel Solution to a Multifaceted Problem," (2014) 5 *The Arbutus Review*, 5, 1, Autumn 2014, p. 144, online: <http://journals.uvic.ca/index.php/arbutus/article/view/13295/4187> (consulted February 5, 2015).

147 *Ibid*.

148 Ivana Spasovska, "On-Reserve First Nations and Health Transfer Policy," *The Journal of History and Political Science*, 1, 2012, online: <http://hpsj.journals.yorku.ca/index.php/hpsj/article/viewFile/36245/32987> (consulted February 5, 2015).

3.1.2
Alberta

In Alberta,[149] First Nations health governance is essentially based on cooperation with Health Canada through the *Co-Management Agreement*, signed in 1996.[150] This co-management agreement gives band chiefs, as representatives of Nations, decision-making power shared with Health Canada.[151] All health decisions affecting Alberta First Nations are taken by a Health Co-Management Committee.[152] Band chiefs represent First Nations and serve alongside two Health Canada representatives. Together, they determine how First Nations health services will be administered, managed, funded, and provided.[153] Recommendations about First Nations' health priorities are forwarded to the committee via subcommittees also made up of band chiefs. These committees are not classified by region but by specialty, such as "Mental Health and Addictions."[154]

149 First Nations in Alberta are a special case because they are affected by three self-government treaties: Treaties 6 (1867), 7 (1877), and 8 (1899), which divide Alberta into territories. Only Treaty 6, signed by the First Nations of northern Alberta and the Cree of Saskatchewan—all located in the central zone—includes a health clause, the "*Medicine Chest Clause*." Under this clause, medications must be provided free of charge to these First Nations through the construction of pharmacies and federal government assistance in the case of a famine or plague. More broadly, Treaty 6 provides for First Nations who live in the central zone to renounce aboriginal rights over the lands there in exchange for numerous measures from the federal government: sums of money, schools, agricultural tools, etc. Treaty 7, signed in 1877 by two Alberta Nations, and Treaty 8, signed in 1899 by the remaining Alberta Nations, also provide for the renunciation of aboriginal rights in exchange for federal subsidies in specific areas, not including health. INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Copy of Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River with Adhesions*, February 24, 1877, online: <https://www.aadnc-aandc.gc.ca/eng/1100100028710/1100100028783> (consulted February 5, 2015).

150 In 1996, the Co-Management Agreement was signed with the Nations who were party to Treaties 7 and 8 (see previous note). The Treaty 6 Nations were very reluctant to sign such an agreement given that they had already acquired and developed certain health powers with the Medicine Chest Clause in their treaty. However, two Treaty 6 Nations would join the Co-Management Agreement: the Yellowhead Tribal Council community in 1999 and the Maskwacis Cree in 2010. HEALTH CANADA, First Nations and Inuit Health – Alberta Region Programs and Services, Ottawa, 2010, p. 24, online: <http://publications.gc.ca/collections/collection_2011/sc-hc/H29-36-2010-eng.pdf>. See also on this topic: Angela-Rose Mashford Pringle, *Self-Determination in Health Care: A Multiple Case Study of Four First Nations Communities in Canada, doctoral thesis, Toronto, Department of Philosophy, University of Toronto, 2013, p. 42. Constance MacIntosh, "Envisioning the Future of Aboriginal Health Under the Health Transfer Process," Health Law Journal*, special edition, 2008, p. 72, online: <http://www.hli.ualberta.ca/HealthLawJournals/~/media/hli/Publications/HLJ/VS-05_MacIntosh.pdf>(consultedJanuary19, 2015). HEALTH CANADA, *First Nations and Inuit Health – Alberta Region Programs and Services*, Ottawa, 2010, p. 26, online: <http://publications.gc.ca/collections/collection_2011/sc-hc/H29-36-2010-eng.pdf>.

151 The purpose of the agreement is to (1) foster cooperation among the partners, (2) establish health continuity, (3) improve access to care and meet the Nations' needs, and (4) meet urgent needs (relating to alcoholism, for example). *Ibid.*, p. 26. This governance model was chosen because the Nations wanted to 1) participate in health decisions, 2) be sure that FNIHB funds would not go down, 3) adopt a cooperative approach, and 4) better understand their health governance.

152 See the committee website: HEALTH CO-MANAGEMENT COMMITTEE, *Committees*, online: <http://hcom.ca/committees/co-management//> (consulted February 4, 2015).

153 The committee is made up of two chiefs from each treaty Nation and two FNIHB representatives. In 2007, the committee experienced problems liaising with the subcommittees, which kept growing in number (rising to 38), resulting in a lack of management transparency. All chiefs were summoned to assess the situation along with the committee and create a permanent working group (the Co-Management Review Working Group) to provide recommendations to the management committee. In 2010, the recommendations were implemented, and the working group continues to support the committee. Health Co-Management Secretariat, *HCOM 101*, February 2014, p. 24.

154 Currently, six health subcommittees and one financial subcommittee. Each subcommittee specializes in one area: (1) Mental Health and Addictions (2) Operations and Support (3) Prevention Programs (4) Non-insured Health Benefits (5) Health Protection, and (6) Children and Youth. Two members from Nations that have signed the Treaties serve as co-chairs to support the subcommittees and foster cooperation. See the Co-Management Committee website: <http://hcom.ca/committees/> (consulted February 4, 2015).

The provincial government, which is not party to the Alberta co-management agreement, is therefore solely responsible for health services normally provided by the province. However, to ensure continuity of services to First Nations, all Nations have a coordinator to liaise with Alberta Health Services (AHS), the provincial organization responsible for providing health care to all citizens. A number of Nations have also entered into individual agreements with this organization.[155]

This health governance makes it possible for Alberta First Nations and Health Canada to share jurisdiction directly within the decision-making committee (Table 7). Our research mainly showed that the subcommittees have plenty of leeway in determining the needs and priorities of First Nations and forwarding this information to the decision-making committee. The subcommittees also apply the committee's decisions. All committees (the Co-Management Committee and the subcommittees) include band chiefs. Band chiefs also serve on the monitoring entities and the political body (Assembly of Treaty Chiefs) responsible for supporting cooperation between Nations and protecting the Nations' interests.[156] However, to our knowledge, this type of governance does not grant Alberta First Nations an alternative method for representation. Overall, the autonomy of First Nations is very limited as there is no transfer of jurisdiction under the co-management agreement. All powers to act are shared and assume the parties are unanimous. Moreover, the agreement only has the legal force of a contract. This means that it can—quite easily—be terminated by one of the parties, unlike an act or a treaty.

155 Sixteen Nations have entered into Primary Care Network agreements with AHS, allowing physicians to offer health services on their reserves. Twelve First Nations have signed formal agreements with AHS for better access to certain special services (mental health, youth, etc.). HEALTH CANADA, *Alberta On-Reserve Health Services and Programs*, Ottawa, 2012, p. 2, online: <http://publications.gc.ca/collections/collection_2012/sc-hc/H34-256-2012-eng.pdf>.

156 The chiefs draw up progress reports for the decisions adopted jointly by the Co-Management Committee and FNIHB. If the reports indicate a lack of progress, the Co-Management Committee is required to respond. In addition, the Assembly liaises with the band councils to ensure in-the-field progress with decisions.

Table 7: Pros and Cons of the Alberta Initiative

Pros	Cons
	Agreement with only the legal force of a contract
Important role of subcommittees	Subcommittees specialize in a topic and not a subregion/region
The subcommittees and decision-making committee include chiefs	Chiefs do not necessarily have management skills
	Monitoring entity ("co-chair") includes chiefs
Chiefs also serve on the political body of governance and the working group supporting the initiative	Renunciation of aboriginal rights
Very quick implementation	Bring Nations together under treaties
Numerous individual agreements with the provincial authority (AHS)	No transfer of jurisdiction for provincial and federal services
	Apart from representation by chiefs, no process for hearing First Nations
	Shared powers to act

3.1.3 Saskatchewan

In August 2008, the Federation of Saskatchewan Indian Nations (now the Federation of Sovereign Indigenous Nations, hereinafter the FSIN)[157] signed a tripartite memorandum of understanding with the provincial health ministry and Health Canada on the federal level Called the *Memorandum of Understanding: First Nations Health & Well-being in Saskatchewan*[158] (hereinafter the "Memorandum"), it is neither a self-government agreement[159] nor a transfer agreement.[160]

Under this memorandum of understanding, Health Canada retains responsibility for its services and the Saskatchewan minister of health retains responsibility for providing

157 It is a democratic political institution whose primary role is to protect and ensure the continuity of treaties but also to promote the development of new partnerships. FEDERATION OF SOVEREIGN INDIGENOUS NATIONS, *Historical Formation*, online: <http://www.fsin.com/about/> (consulted February 8, 2015). It is made up of a legislative assembly bringing together the assembly of chiefs, all vice-chiefs, the tribal agency, the veterans association, and the First Nations Women's Council: FEDERATION OF SOVEREIGN INDIGENOUS NATIONS, *Legislative Assembly*, online: <http://www.fsin.com/index.php/legislative-assembly> (consulted February 8, 2015). It also includes a senate, an executive council, and a number of subcommittees. The subcommittees are tasked with assessing situations, drawing up studies, or responding to requests submitted to the legislative assembly. After consulting with the senate, the legislative assembly determines whether the request should be acted on by the executive council. Although this structure resembles our legislative system and seems complex, it is important to note it has no legislative authority. It only provides guidelines.

158 THE FEDERATION OF SASKATCHEWAN INDIAN NATIONS, GOVERNMENT OF CANADA, AND GOVERNMENT OF SASKATCHEWAN, *Memorandum of Understanding: First Nations Health & Well-being in Saskatchewan*, August 19, 2008, online: <http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/services/2008-sask-mou-pde-eng.pdf> (consulted April 8, 2015).

159 *Supra*, p. 18.

160 *Supra*, p. 21.

health services to the entire population, including First Nations.[161] However, the parties agree to cooperate to improve First Nations health and wellbeing, by making health decisions jointly and by reducing the duplication of services. The underlying goal of the initiative is to establish a ten-year health plan that takes into consideration the priorities of First Nations[162] and to increase the numbers of First Nations members working in health.[163] Furthermore, like the governance method selected in Alberta, an intergovernmental committee (Steering Committee), made up of two members from each of the three partners, has been put in place to ensure successful implementation of the Memorandum and establish a tripartite decision-making process.[164]

To date, numerous projects have been put in place since this governance structure was introduced but they are specific to certain aspects of First Nations health, such as e-health.[165] The issues of respect for the values of First Nations and of the organization of and access to health care are still not resolved, with the Saskatchewan health ministry continuing to develop health plans that do not fully reflect First Nations' interests.[166]

Although it does not have the legal force of Section 35 of the *Constitution Act, 1982*[167] but rather the force of common contract law, it is important to understand that the Memorandum follows on from the self-government treaties signed in the late 19th century.[168] It is therefore the continuation of a lengthy historic claims process. Although health is not the primary objective of these treaties, as only one includes a health clause (*Medicine Chest Clause*),[169] Quebec First Nations would certainly lack this historic aspect if they choose this initiative. Under the treaties, Saskatchewan First Nations had already joined together and were working towards the same goal. The first step had therefore already been taken.

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161 *The Department of Health Act*, H.C., 1996, c. 8. IPAC, MNP and FASKEN MARTINEAU, *Healthcare Governance Models in Canada: Saskatchewan*, 2013, p. 14, online: <http://www.ipac.ca/documents/ALL-COMBINED.pdf> (consulted April 8, 2015).

162 *Ibid.*, Section 1.

163 HEALTH CANADA, *Canada, Saskatchewan and Saskatchewan First Nations Team Together to Improve First Nations Health in Saskatchewan*, press release, Ottawa, August 19, 2008, online: <http://www.marketwired.com/press-release/canada-saskatchewan-saskatchewan-first-nations-team-together-improve-first-nations-health-891216.htm>.

164 *Ibid.*

165 HEALTH CANADA, *Harper Government Invests To Improve e-Health in Saskatchewan First Nations - Partnership Will Help Improve Health Services*, press release, July 31, 2012, online: <http://news.gc.ca/web/article-en.do?nid=688519&_ga=1.139456432.222670126.1480693455.

166 GOVERNMENT OF SASKATCHEWAN, *Saskatchewan Provincial Budget 14-15*, Regina, 2014, online: <http://www.finance.gov.sk.ca/PlanningAndReporting/2014-15/GovernmentDirection1415.pdf> (consulted April 8, 2015).

167 *Constitution Act, 1982*, Section 35.

168 All the treaties can be found on this federal government page: GOVERNMENT OF CANADA, INDIGENOUS AND NORTHERN AFFAIRS CANADA, *Treaty Texts*, online: <http://www.aadnc-aandc.gc.ca/eng/1370373165583/1370373202340> (consulted February 8, 2015). See on this topic: HAWORTH-BROCKMAN Margaret, Kathy BENT, and Joanne HAVELOCK, "Research, Entitlements and Health Services for First Nations and Métis Women in Manitoba and Saskatchewan," International Journal of Indigenous Health 4, 2 , 2009, p. 15, online: <https://journals.uvic.ca/index.php/ijih/article/view/12322> (consulted April 8, 2015).

169 This clause specifies that medical supplies must be free for these First Nations. See above. INDIGENOUS AND NORTHERN AFFAIRS CANADA, *op. cit.*, Note 149.

In practice, the Memorandum creates a formal partnership between the three parties to enhance participation by Saskatchewan First Nations in health. However, it does not give them any autonomy as such. It only sets mutual objectives for improved health.[170] On the one hand, there is no transfer of jurisdiction for provincial or federal services, and on the other hand, powers to act are shared between band chiefs, official First Nations representatives, and government representatives (Table 8). The primary advantage of shared jurisdiction is that governance is fully integrated in the provincial health network.

Table 8: Pros and Cons of the Saskatchewan Initiative

Pros	Cons
Structure for sharing health jurisdiction	Agreement with only the legal force of a contract
Tripartite structure between First Nations, the federal government, and the provincial government	Renunciation of aboriginal rights under previous self-government treaties
Very quick implementation	Issue of respect for First Nations' values not resolved
Integrated in the provincial health network	Shared powers to act
	No transfer of jurisdiction for provincial and federal services
	Apart from representation by chiefs, no process for hearing First Nations

3.1.4 The Cree

In 1975, along with other parties[171] including the Government of Quebec, the Cree signed the *The James Bay and Northern Quebec Agreement*[172] (hereinafter the "Agreement"), granting the Cree a certain degree of self-determination for health.

The Agreement is first and foremost a treaty, which represents a compromise between the parties. It helped the Cree preserve their territorial hunting and fishing rights[173] and gain benefits[174] including the creation of local and regional administrations for education,

170 Angela-Rose Mashford Pringle, *op. cit.*, Note 150, p. 42.

171 The signatories are the Quebec government, the James Bay Energy Corporation, Société de développement de la Baie-James, Hydro-Québec, and the Quebec Grand Council of the Crees, the James Bay Cree, the Northern Quebec Inuit Association, the Quebec Inuit, the Port Burwell Inuit, and the Canadian government. *Ibid*. In the beginning, the James Bay Cree were a nomad people who hunted and trapped to meet their needs. They maintained their health thanks to the medicinal traditions passed down through the generations. These traditions mostly used flora and fauna to treat diseases. Once they had contact with Europeans, the Cree soon became involved in the Hudson Bay Company fur trade. Such contact fostered the spread of diseases previously unknown to First Nations. Their medical knowledge and health structure were thrown into chaos because generations of healers were wiped out by disease. First Nations began to question their medical know-how. Joseph Franklin, *La perception de l'autonomie gouvernementale par les Cris du Québec*, dissertation in support of a master's in Religious Human Sciences, Faculty of Theology, Ethics, and Philosophy, Université de Sherbrooke, 2000, p. 44 and 88.

172 *James Bay and Northern Quebec Agreement*, *op. cit.*, Note 68.

173 Jacques-Guy Petit, "Cris et Inuits du Nord du Québec : deux peuples entre tradition et modernité (1975-2010)" in Jacques-Guy Petit, Yves Bonnier Viger, Pita Aatami, and Ashley Iserhoff, Editors. *Les Inuits et les Cris du Nord du Québec*, Québec City, Presses de l'Université du Québec, 2011, p. 16.

174 *James Bay and Northern Quebec Agreement, 1975, op. cit.*, Note 68, Subsections 2.2 and 2.3.

health, and social services.[175] In exchange, the Cree had to renounce their aboriginal rights[176] and allow the Government of Quebec to build hydroelectric dams to make Quebec energy independent and boost Hydro-Québec's operations.[177] For the Cree, signing the Agreement was the first step towards autonomous health governance and a healthier Cree Nation despite the lack of provisions on self-government in health per se. [178] To make the Agreement permanent, the Quebec National Assembly adopted the *Act approving the Agreement concerning James Bay and Northern Quebec*,[179] making the provisions of the agreement legally binding by modifying the existing laws of general application. Moreover, special laws were adopted, including the *Act respecting health services and social services for Cree Native persons* relating to health, which reinforced the Agreement.[180]

As mentioned in the first chapter and in spite of the Agreement, the Government of Quebec develops, organizes, and delivers health services to all Quebecers, including Cree First Nations.[181] In theory, Cree First Nations must have access to the same care as the rest of the Quebec population, under the same conditions. Since the Agreement was signed, it appears that health governance has significantly improved the health of the Cree Nation.[182] James Bay health conditions and programs have been improved, leading to a decrease in infectious diseases and an increase in medical follow-up.[183] This governance model thus seems to have had positive effects. However, the Cree are trying to improve it to better reflect the needs and realities of their Nation (see Table 9 for the pros and cons of this initiative).

The Agreement is unique because it transfers responsibility for health services from the federal government to the provincial government and the Cree Nation and because it grants the Cree the power to administer and provide health services, and manage the associated budget, through a Quebec health network entity—the Cree Council.

175 Sébastien Grammond, "Les effets juridiques de la Convention de la Baie-James au regard du droit interne canadien et québécois," (1991–1992) 37 *McGill Law Journal*, 37, 761, 1992, p. 763.

176 *James Bay and Northern Quebec Agreement*, *1975, op. cit.*, Note 68, Subsection 2.1.

177 It was not until the early 1970s that the Cree adopted a governance model unlike those used by other Nations. At that time, Hydro-Québec planned to build hydroelectric dams on the La Grande, Grande-Baleine, Nottaway, Broadback, and Rupert Rivers. The Cree were not in favour and initiated a legal battle against the Government of Quebec based on their claim to territorial rights. Joseph Franklin, *op. cit.*, Note 172, p. 47.

178 Even though "self-government is considered a condition sine qua non to improving health for First Nations": Thibault Martin and Éric Diotte, "Politiques publiques et santé des Autochtones résidant en milieu urbain: l'autonomie gouvernementale, une condition de la redéfinition d'un partenariat équitable entre l'État et les Autochtones" in Jerry P. White and Jodi Bruhn (Editors), *Aboriginal Policy Research Volume VIII. Exploring the Urban Landscape*, Ed. Thompson, Toronto, 2010, p. 107 and 108, online: <http://apr.thompsonbooks.com/vols/APR_Vol_8Ch6.pdf>.

179 *James Bay and Northern Quebec Agreement*, *1975, op. cit.*, Note 68, Subsection 2.5.

180 *Act respecting health services and social services for Cree Native persons*, CQLR, c. S-5.

181 *The Constitutional Act, 1867*, Subsections 92(7). 92(13), and 92(16). *HEALTH CANADA, op. cit.*, Note 15, p. 7.

182 Joseph Franklin, *op. cit.*, Note 172, p. 92.

183 *Id.*

The main advantage of this governance initiative is no doubt the constitutional protection benefiting modern treaties under Section 35 of the *Constitution Act, 1982*.[184] As parliaments cannot unilaterally modify governance,[185] Cree Nation institutions enjoy greater stability. Government relations can then be viewed in a spirit of long-term change. However, the right to self-government is not provided. So, unlike a self-government agreement, the Agreement does not authorize the Cree to pass health laws. This lack of power only has a slight impact on health governance. The power needed to properly manage health has been transferred to the Cree Council.

It is also beneficial for the Cree Nation to maintain a governance model that ensures health decisions are made by its members. The Cree Council ensures that the health interests of the First Nation will be represented. In addition, the powers of the Cree Council then make it possible to apply these interests in the field. Although the Government of Quebec's responsibilities are delegated to the Cree Council, the Council maintains a direct link to the Quebec health network. Cree health governance is therefore fully integrated in the network. This special situation leads us to believe that agreements between the Cree Council and the other network institutions and the connection with specialized and subspecialized services are more easily achieved.

This governance model would not meet FNQLHSSC expectations. Such an agreement could not be signed today without abandoning certain claims. In addition, this initiative's applicability to Quebec depends primarily on the cumbersome implementation process. It is a tripartite governance model between the Government of Canada, the provincial government, and First Nations. Its implementation in Quebec depends mainly on the willingness of the governments to negotiate with First Nations. In the case of the Agreement, right from the start the provincial government wanted to enter into an agreement with First Nations to develop a local hydroelectric network. Negotiations were thus easier to initiate. The Cree initiative is part of a modern treaty or land claim agreement. All aspects of First Nations governance must be negotiated, after which sector-specific agreements can be signed. This path is definitely not the easiest. Once the modern treaty has been signed, governments will have to draw up governing statutes for implementing the agreement's provisions. In addition, certain complementary statutes may have to be adopted or amended. Although this governance model is appealing for its nature and scope, its application is less straightforward.

184 *Supra*, p. 10 et seq.

185 Ghislain Otis and Geneviève Motard, *op. cit.*, Note 69, p. 135.

Table 9: Pros and Cons of the Cree Initiative

Pros	Cons
Powers to act transferred to the Cree Nation	Cumbersome implementation process
Constitutional protection for treaties	Lack of self-government
First Nations representation	Renunciation of their aboriginal title
Integration in the health network	

Up to this point, in this section we have presented Canadian health governance models since the constitutional framework set out in Chapter 1 is the same as for Quebec First Nations. The Maori health governance model set out below is not subject to the same constitutional rules. However, we felt it was important to analyze, given its success (Subsection 3.1.5).

3.1.5 New Zealand (Maori)

In New Zealand the Maori First Nations developed a governance system based on cooperation with the government. Although it does not give the Maori fully autonomous governance, the model is often used as an example because it is so successful.[186]

This cooperative governance system dates back to the signing of the *Treaty of Waitangi* on February 6, 1840, by the British Crown and the Maori nations. It was a cession treaty, meaning—and in our opinion this is the biggest disadvantage of the initiative—that the Maori had to renounce their aboriginal rights. The main objectives were not recognition of the Maori right to autonomy, but, as provided by the treaty's underlying principles: 1) Protection from the Crown and equality among peoples, 2) Community participation in the provision of and access to care as well as in organization and decision making, and 3) More partnerships between the Crown and the Maori.[187] Enshrined in 2000 in the enabling statute, the *Public Health and Disability Act*,[188] in practice these principles allow the

186 Meredith Gibbs, "The Right to Development and Indigenous People: Lessons from New Zealand" *World Development*, 33, 8, February 2005, 1365-1378.

187 When it was signed, the treaty was translated into English and Maori. But the English version gives more powers to the Crown while the Maori version gives the Maori a certain degree of control over their institutions. In 1975, the Waitangi Tribunal was created, also serving as a commission of inquiry to resolve issues of interpretation between the two versions of the treaty and allow them to coexist. The tribunal recommended that all stakeholders (the Waitangi Tribunal, the New Zealand government, the Appeal Court, and the New Zealand Maori Council) develop their own interpretation. In 1988 all common principles on the connection between the treaty and Maori health were identified. Te Kani Kingi, "The Treaty of Waitangi: A Framework for Māori Health Development," *New Zealand Journal of Occupational Therapy, 54, 1, March 2007, p. 4 and 8.*

188 *Public Health and Disability Act*, 2000, No 91, Paragraph 3(1)*b)* and Section 4: "to reduce health disparities by improving the health outcomes of Maori and other population groups" and *Treaty of Waitangi*, respectively. This act led to heated debates in Parliament and is still challenged today. Those who oppose it claim the principles give the Maori special privileges: *ibid.*, p. 9. Furthermore, significant racism still exists between Maori and non-Maori populations in the country: Joy Colleen Panoho, *A Māori-centred inquiry into health governance: Māori directors on District Health Boards*, doctoral thesis, Palmerston North, Department of Philosophy, Massey University, New Zealand, 2012, p. 48.

Maori to actively participate in health decisions. The main advantage of such governance is protection under a treaty as well as from a governing statute that gives the Maori guaranteed stability.

The success of this governance method (see Table 10 for a summary) is also the result of Maori being well established in management positions on *District Health Boards* (DHB), [189]regional health entities responsible for organizing and providing health care in their assigned district.[190] First of all, each DHB is legally required to participate in the development and improvement of health services to the Maori population.[191] To this end the DHBs must each produce a health plan for the Maori nations in their region.[192] Therefore, there are as many plans as Maori nations. Next, members of these entities must be familiar enough with the *Treaty of Waitangi* that they can promote Maori values. Not only are Maori fully represented in the main health management positions, but staff who provide their health care also take classes on Maori culture. For example, training courses in Maori culture are included in certain nursing programs.[193] Finally, and most importantly, Maori—not necessarily chiefs but people who have acquired health management skills—must be represented on each DHB.[194] Each of the three DHB committees[195] must include at least two Maori representatives,[196] proportionate to the population served by the DHB.[197] This means that in practice, Maori participate in each decision about healthcare administration, finance, delivery, and access within their DHB.

In addition, New Zealand allows Maori to jointly purchase, with the government and using government funds, health institutions operated "by Maori, for Maori," and to enter into agreements with service providers.[198] This policy (the *National Primary Health Care*

189 *Public Health and Disability Act*, *op. cit.*, Note 188, Section 5.

190 Joy Colleen Panoho, *op. cit.*, Note 188, p. 29. They are made up of seven elected members and four members appointed by the Ministry of Health. *Public Health and Disability Act, op. cit.*, Note 188, Subsection 29(3). Each DHB has three standing committees (Community and Public Health Advisory Committee, Disability Support Advisory Committee, Hospital Advisory Committee). *Ibid.*, Subsection 5(4).

191 *Ibid.*, Section 23.

192 See the New Zealand government website, health plans: MINISTRY OF HEALTH, *DHB Māori Health Plans, profiles and summaries*, online: <http://www.health.govt.nz/our-work/populations/maori-health/dhb-maori-health-plans-profiles-and-summaries> (consulted February 5, 2015).

193 Derek Hand, "Indigenous Health in New Zealand: 'By Maori, for Maori' », *Australian Nursing Journal*, 5, 10, May 1998, 18-20, online: <https://studylib.net/doc/10539686/-by-maori--for-maori--indigenous-health-in-new-zealand→.

194 *Public Health and Disability Act*, Paragraph 5(3)(a).

195 *Ibid.*, Sections 34, 35, and 36.

196 *Ibid.*, Paragraph 29(4)*b)*.

197 Ibid., Paragraph 29(4)*a)*.

198 MINISTRY OF HEALTH, *He Korowai Oranga: Māori Health Strategy* by A. King and T. Turia, Wellington, 2002, online: <http://www.health.govt.nz/system/files/documents/publications/mhs-english.pdf> (consulted February 5, 2015). Starting in 2002, such contracts became a priority and in 2006, more than 240 Maori providers were involved in providing health care to Maori. Ian Anderson, Sue Crengle, Martina Leialoha Kamaka, Tai-Ho Chen, Neal Palafox, Lisa Jackson-Pulver, "Indigenous health in Australia, New Zealand, and the Pacific," *The Lancet*, 367, 9524, May 27, 2006, p. 1784.

Strategy), introduced nationally in 2001[199] by the New Zealand government, fosters a better understanding of Maori culture in the delivery of care, a concept that is essential for Maori First Nations. However, it seems that in practice, free competition is not feasible—most contracts are signed with the same Maori providers. Apparently very few non-Maori dare to invest in health infrastructure primarily intended for Maori.[200] These same providers can then raise their prices, which creates a burden and restricts the achievement of local priorities.[201] For this reason, Primary Health Organizations, non-profit entities, were introduced to monitor contracts signed with providers.[202]

Table 10: Pros and Cons of the Maori Initiative

Pros	Cons
Maori priorities set out in legislation	Renunciation of aboriginal rights
Maori (not necessarily chiefs but people with relevant skills) must be represented in regional health entities	Cooperation and not autonomy (joint decision making)
Maori health priorities established in regional health plans	
Power to enter into provider contracts with Maori	Distorted competition in assigning contracts
Maori culture preserved in healthcare practices	

3.2 ORGANIZATIONAL OUTLOOK FOR AGREEMENTS TO IMPLEMENT FIRST NATIONS AUTONOMOUS GOVERNANCE

The second section of this chapter will present and analyze two health governance models enshrined in self-government agreements, one in Alaska, United States, and the other in the Yukon, Canada. These two First Nations are the only ones with health jurisdiction in their territory. Given current constitutional restrictions in both countries, these models are the most sophisticated. Therefore their implementation process can be long.

199 Josée G. Lavoie, "Governed by Contracts: The Development of Indigenous Primary Health Services in Canada, Australia and New Zealand," *Journal of Aboriginal Health*, January 2004, p. 16, online: <http://www.naho.ca/jah/english/jah01_01/journal_p6-25.pdf> (consulted April 8, 2015).

200 Josée G. Lavoie, Amohia Boulton, and Judith Dwyer, "Analysing contractual environments: lessons from Indigenous health in Canada, Australia and New Zealand," *Public Administration*, 88, 3, September 2010, p. 673. As an example, Korowai Aroha is a health centre in Rotorua established in 1992 and operated by Maori nurses for Maori people. Derek Hand, *op. cit.*, Note 193.

201 *Ibid.*, p. 670.

202 *Ibid.*, p. 671. See also: Sally ABEL et al. "Implementing the Primary Health Care Strategy: A Māori Health Provider Perspective," *Social Policy Journal of New Zealand, Te Puna Whakaaro*, 25, July 2005, online: <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj25/implementing-the-primary-health-care-strategy25-pages70-87.html> (consulted February 5, 2015).

3.2.1
Alaska

The health governance model implemented for Alaska First Nations since 1994 is known as the Alaska Native Health System. It is a complete and standardized governance model, but interestingly it is not fully centralized. The Nations it benefits did not opt for centralized jurisdiction within a third-party organization as in British Columbia. Instead, they decided to preserve the autonomy already acquired by entrusting powers to act on health either to local health agencies (mostly band councils) or regional organizations.

The governance model is based on the *Indian Self-Determination and Education Assistance Act*, [203] which since 1975 has allowed First Nations to be almost fully responsible for management of their health services via local health agencies and twelve autonomous, not-for-profit regional health agencies,[204] for First Nations that have voluntarily partnered with such agencies. At that time, these health authorities were responsible for managing health funds transferred to them by the federal government to provide health care to beneficiaries. However, they were still under the control of the American federal government,[205] whose approval was required (in the form of contracts) before they could plan or provide new services or programs. The implementation process for this governance method stems from a long string of claims and also requires the participation of all stakeholders.

In 1994, health governance became fully autonomous with the signing of the Alaska Tribal Health Compact (*ATHC*), [206] an agreement granting powers to act on health to First Nations who wanted to join the compact and characterizing the relationship between the Nations and the American government as a relationship "of equals." An autonomy agreement offers the most sophisticated governance model. The agreement has the highest possible legal force. Now, all Alaska First Nations health agencies (local or regional) have the necessary powers to act on financing, determining, administering, managing, and providing health services for their respective populations.[207] They can also sign contracts directly with

203 *Indian Self-Determination and Education Assistance Act*, Public Law 93-638.

204 In 1971, the *Alaska Native Claims Settlement Act* reorganized Indian territories and grouped villages into regions. Tracy L. Speier, *In-State Contract Health Services and Emergency Care within the Alaska Tribal Health System: A Policy Process Analysis*, master's dissertation, University of Alaska Anchorage, 2004, p. 8 and 9, online: <http://www.mpaalaska.org/wp-content/uploads/2013/03/Speier.pdf> (consulted March 10, 2015).

205 The United States government must provide health services to the entire population, including First Nations: *Constitution of 1787*, United States, Article 1, Section 8. For this reason and although health services are managed by First Nations, aboriginal peoples are eligible for Medicare and Medicaid programs. To successfully carry out this mission, the *Snyder Act*, Public Law 67-85, 1921 established the *Indian Health Service* (equivalent to the Canadian FNIHB) within the Bureau of Indian Affairs at the Department of Interior, which was transferred in 1954 to the Public Health Service at the Department of Health and Human Services. Ibid., p. 7.

206 See on this topic: Paul Sherry, "Health care delivery for Alaska Natives: <http://journals.co-action.net/index.php/ijch/article/viewFile/17786/20261> (consulted April 8, 2015).

207 Tracy L. Speier, *In-State Contract Health Services and Emergency Care within the Alaska Tribal Health System: A Policy Process Analysis*, master's dissertation, University of Alaska Anchorage, 2004, p. 10, online: <http://www.mpaalaska.org/wp-content/uploads/2013/03/Speier.pdf> (consulted March 10, 2015).

service providers or sign new funding agreements with the federal government. However, it is important to note that autonomy is not absolute as First Nations still do not have the power to adopt laws.

Since 1998, 99% of Alaska First Nations health services have been managed either by First Nations themselves or by third-party, non-centralized First Nations entities. Just one community (Metlakatla Indian Community) has chosen not to participate and is thus still under the responsibility of the federal government, with which it must enter into contracts to obtain new services.

However, as Nations share certain infrastructure, the Alaska Native Tribal Health Consortium[208] was created under the autonomy agreement to administer these joint health services.[209] Decisions are taken jointly as the consortium is made up of fifteen members representing health agencies (local or regional) as well as two members from unaffiliated Nations, i.e., Nations that have decided not to participate in autonomous governance and are still under the responsibility of the federal government.[210] Unlike agencies in all First Nations elsewhere in the United States, all local or regional Alaska First Nations health agencies are made up of members of their First Nations and these Nations, as "autonomous governments," take all health decisions.[211]

Table 11: Pros and Cons of the Alaska Initiative

Pros	Cons
Self-government agreement: Significant legal force	Very long implementation process (Nations divided up, grouped or not within entities, etc.)
Full autonomy for Nations	Only power missing: legislative authority
Autonomy not required to be transferred to a third-party entity (unless there are common structures), but it can be	Requirement for all First Nations and governments to be onboard
Shared infrastructure managed by a third-party aboriginal entity	

208 The Alaska Native Medical Center, for hospitals.

209 *Snyder Act*, Section 325.

210 These are Nations that do not take part in the initiative and are under the responsibility of the federal government.

211 Leanna Ellsworth and Annmaree O'Keeffe, "Circumpolar Inuit health systems," (2013) *International Journal of Circumpolar Health* 72, online: <http://www.circumpolarhealthjournal.net/index.php/ijch/article/view/21402> (consulted March 10, 2015).

3.2.2
The Yukon

As in Alaska, a self-government agreement was signed in the Yukon by First Nations and the Canadian government authorities.[212] However, unlike the Alaska agreement, this is a framework agreement as each of the fourteen Yukon First Nations had to sign a self-government agreement with both governments.[213] These self-government agreements, as explained in Chapter 1, recognize signatory First Nations as autonomous entities[214] and no longer as bands, as defined by the *Indian Act*. Then, the *First Nations (Yukon) Self-Government Act*[215] adopted by the Parliament of Canada subsequently completed the agreement in 2002 by granting the power to pass legislation. Such power is not part of the governance system for Alaska First Nations.

Self-government agreements recognize the Nations in question as governments and establish the framework for their relationships with the provincial and federal governments. In this way, the federal and provincial governments have given First Nations powers for developing, managing, administering, and funding health in their territories. But most importantly, the agreements allow First Nations to enter into contracts and pass legislation in the interests of their population.[216] For example, they can create new taxes. Yukon First Nations thus have powers and responsibilities—not just regarding health—on the same basis as territorial governments.[217]

For health, this means that as a government, each First Nation signatory community[218] has full powers to act. However, the Department of Health and Social Development of the Council of Yukon First Nations (CYFN) acts as coordinator between the governments and helps the Nations to develop their health programs. [219] In addition, the Yukon is the only

212 INDIGENOUS AND NORTHERN AFFAIRS CANADA, Umbrella Final Agreement Between The Government Of Canada, The Council For Yukon Indians And The Government Of The Yukon, Whitehorse, May 29, 1993, online: https://www.aadnc-aandc.gc.ca/eng/1297278586814/1297278924701

213 PARLIAMENT OF CANADA, *Aboriginal Self-Government* by Jill Wherrett, Library of Parliament, Ottawa, 1999, online: http://www.bdp.parl.gc.ca/content/lop/researchpublications/962-e.htm#3. Yukon-t (consulted April 8, 2015).

214 *First Nations (Yukon) Self-Government Act*, RSY, c. 90, Section 8.

215 *Ibid*.

216 *Ibid.*, Subsection 11(1).

217 INDIGENOUS AND NORTHERN AFFAIRS CANADA, Building The Future: Yukon First Nation Self-Government, Ottawa, 2008, online: <http://www.aadnc-aandc.gc.ca/eng/1316214942825/1316215019710> (consulted April 8, 2015).

218 See the list in: *First Nations (Yukon) Self-Government Act*, Column II, Appendix I,

219 CYFN is made up of a general assembly (bringing band chiefs together) and numerous committees (on health, law, natural resources, etc.) each with its own specialized subcommittees (on health, for example: Mental Health Committee). OFFICE OF THE AUDITOR GENERAL OF CANADA, *Yukon Health Services and Programs – 2011 Department of Health and Social Services*, 2011 February Report of the Auditor General of Canada, Ottawa, 2011, p. 4, online: <http://www.oag-bvg.gc.ca/internet/docs/yuk_201102_e_34985.pdf> (consulted February 6, 2015). NATIONAL COLLABORATING CENTRE FOR ABORIGINAL HEALTH, *The Aboriginal Health Legislation and Policy Framework in Canada* by Josée G. Lavoie, Prince Georges, 2011, online: <http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/2/Health%20Legislation%20and%20Policy_English.pdf> (consulted April 8, 2015).

Canadian province that has passed legislation recognizing the need to observe First Nation cultural norms in delivering health services.[220]

It is however important to mention that substantial time was needed (almost two decades) to put self-government in place for Yukon First Nations. The movement towards self-government began in 1968 when Canadian First Nations came together to speak with one voice and claim new rights from government authorities.[221] The final land claim framework agreement was not signed until 1993.[222] This framework agreement, which has the force of a treaty under Section 35 of the *Constitution Act, 1982*, formed the basis for negotiations between Yukon First Nations and the federal and provincial governments. Several decades separate the first claims from the adoption, in 1993, of the *Yukon First Nations Self Government Act*, which was improved in 2002.

According to CYFN, it took this long because of changes in politics, society, and identity at the time and because of the difficulty in reconciling all the expectations of all Nations, considering in particular that First Nations viewed giving up their aboriginal rights as inconceivable.[223] So CYFN held firm and decided to continue with negotiations, aware nonetheless that much more time would be needed.[224]

Under this governance system, the Yukon Hospital Corporation (YHC), responsible for managing services and programs offered at the three Yukon hospitals, developed a First Nations health program in 1990, whereby services provided are chosen, funded, and provided by the First Nations Council, one of the YHC committees.[225] Moreover, health liaison agents address poor communication between patients and physicians, who are required to respect their patients' cultural norms.[226] Services and programs not offered in

220 *Ibid*.

221 In the Yukon, this led in 1973 to the "Together Today for our Children Tomorrow" presentation when the main Yukon chiefs and the two representative organizations—the Yukon Association of Non-Status Indians and the Yukon Native Brotherhood—met with Prime Minister Pierre Elliott Trudeau to demand a treaty for autonomy. In 1979, the provincial government became the third party to join negotiations and the formation of the CYFN was complete. COUNCIL OF YUKON FIRST NATIONS, *History of Land Claims*, online: <http://cyfn.ca/history/history-of-land-claims/> (consulted February 6, 2015). In 1973, to be in a position to enter into such an agreement, Yukon First Nations decided to regroup and formed the Council for Yukon Indians, which later became CYFN.

222 EXECUTIVE COUNCIL OFFICE, *Umbrella Final Agreement* covering final agreements with First Nations and rights granted under treaties, online: <http://www.eco.gov.yk.ca/fr/landclaims/about.html> (consulted April 8, 2015). In 1993, the final umbrella agreement granting autonomy to each of the 14 Yukon Nations, without the need to renounce their rights, was signed. The model of governance specified in the agreement was put in place with the CYFN and one by one, autonomy agreements were signed with individual Nations. THE GOVERNMENT OF CANADA, THE COUNCIL FOR YUKON INDIANS, and THE GOVERNMENT OF YUKON, *Umbrella Final Agreement*, 1993, online: http://cyfn.ca/ufa/> (consulted February 7, 2015). In 1994, the *Yukon First Nations Self-Government Act*, S.C. 1994, c. 35 specified that the 14 Nations have authority over their reserve. In 2008, two Nations had yet to sign—Liard First Nation and Ross River Dena Council. INDIGENOUS AND NORTHERN AFFAIRS CANADA, *op.cit.*, Note 217.

223 Marian C. Horne, "Yukon's Self Governing First Nations," (2010) 33 *Canadian Parliamentary Review* 2, online: <http://www.revparl.ca/33/2/33n2_10e_Horne.pdf> (consulted February 6, 2015).

224 COUNCIL OF YUKON FIRST NATIONS, *op. cit.*, Note 221.

225 IAPC, MNP and Fasken Martineau, *op. cit.*, Note 161, p. 51 and 53.

226 Kali Romano, Amy Passmore, Trent Kellock, and Jennifer Nevin, "Understanding Integrated Care: The Aboriginal Health Initiative Heads North," (2013) *University of British Columbia Medical Journal*, 3, 1, September 2011, p. 35, online: <https://ubcmedicaljournal.files.wordpress.com/2015/11/ubcmj_3_1_2011_34-35.pdf> (consulted April 8, 2015).

hospitals are provided in local First Nation health centres that may be under the authority of their reserve thanks to the self-government agreement or under the responsibility of the provincial government.[227] However, YHC cooperates with the provincial government, submitting a comprehensive twice-yearly report on health programs provided.[228]

Table 12: Pros and Cons of the Yukon Initiative

Pros	Cons
Self-government agreement: Significant legal force	Very slow to implement
Full powers to act: with the power to enact laws	Requirement for all First Nations and governments to be onboard
No shared jurisdiction	Option of coming together under regional entities not provided?
No transfer to a third-party entity	
Aboriginal values recognized in legislation	

CONCLUSION

As mentioned, the health governance models we discussed, implemented by certain Canadian provinces and abroad, vary in the degree of powers to act they confer to First Nations. Most of the examples are from Canadian provinces as they have the potential to be implemented within the same constitutional framework, unlike the models in Alaska and New Zealand.

These models provide inspiration for a range of health governance options for Quebec First Nations, with varying degrees of self-governance. One option might be shared governance where members of First Nations either co-lead the decision-making committee along with Health Canada representatives (Alberta and Saskatchewan) or serve on each heath authority (New Zealand). In such cases, there is no transfer of responsibilities but merely close cooperation between partners. In more sophisticated arrangements, powers to act on the administration, management, funding, and provision of health services can be transferred to First Nations through a transfer agreement requiring the creation of a third-party health entity tasked with this responsibility (British Columbia, Cree). Finally, fully autonomous governance like that in place for Yukon and Alaska First Nations can be envisaged. This offers the most autonomy and therefore takes much longer to implement. It also requires a reconciliation of interests.

227 OFFICE OF THE AUDITOR GENERAL, *op. cit.*, Note 219.

228 Josée G. Lavoie, "Policy silences: why Canada needs a National First Nations, Inuit and Métis health policy," (2013) International Journal of Circumpolar Health 72, p. 4, online: <http://health.chiefs-of-ontario.org/sites/default/files/attachments/Policy%20Silences%20Why%20Canada%20Needs%20a%20National%20First%20Nations,%20Inuit%20and%20Metis%20Health%20Policy.pdf> (consulted April 8, 2015).

All the initiatives discussed represent a major step forward as they all require Nations to come together and negotiate jointly with the government(s). There are various options for establishing one of these types of governance—treaties, memorandums, contracts, or legislation.

4
CONCLUSION

This report is a preliminary work intended to present the results of analyses carried out to date. To this end, we have collected and responded to comments from FNQLHSSC in order to finalize the report and our conclusion.

The current legislative framework means participation by First Nations in developing the health programs provided to them is minimal. In practice, the options given here are not enough for First Nations to be able to share and receive recognition for their needs and priorities. However, this legislative framework can grant First Nations broader powers to act and thus improve their local governance.

As mentioned, numerous legal tools are available (agreements, treaties, memorandums, legislation) and different degrees of governance are possible (co-management, transfer, or autonomy). Depending on the degree of self-determination sought, bringing Nations together and negotiating with the government(s) over fairly long periods require a shared commitment and a certain level of consensus within Nations. This is achievable, but may take time.

For this reason, without the need to combine preferences, in Chapter 2 we suggest solutions for improving local governance in the short term by (1) strengthening the relationship between Nations and the institutions that serve them, in particular through agreements and the participation of community representatives within such institutions (on the board of directors or user committee, for example); (2) improving health management expertise among band councils; (3) increasing citizen participation in local decision making.

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The report highlights the legal framework for providing and delivering health care to First Nations as well as the processes envisaged in terms of autonomy. These elements help to understand how the voice of First Nations can be heard in the current system.

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